

THE STATE OF HEALTH INSURANCE MARKETS

HEARING

BEFORE THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

SEPTEMBER 15, 2016

Available via the World Wide Web: <http://www.fdsys.gov/>

Printed for the use of the
Committee on Homeland Security and Governmental Affairs



U.S. GOVERNMENT PUBLISHING OFFICE

25-159 PDF

WASHINGTON : 2018

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

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THE STATE OF HEALTH INSURANCE MARKETS

THURSDAY, SEPTEMBER 15, 2016

U.S. SENATE,
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:03 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Ron Johnson, Chairman of the Committee, presiding.

Present: Senators Johnson, McCain, Portman, Lankford, Ernst, Sasse, Carper, Tester, and Peters.

OPENING STATEMENT OF CHAIRMAN JOHNSON

Chairman JOHNSON. Good morning.

This hearing of the Senate Homeland Security and Governmental Affairs Committee (HSGAC) will come to order.

The subject of the hearing today is the state of the health insurance markets.

I want to thank all of our witnesses for your thoughtful testimonies and for traveling here. It is a beautiful city you got. You brought beautiful weather, by the way. It is not quite as hot and humid as it normally is, but I really do appreciate you coming here for a very important subject.

The truth of the matter is, the reason I decided to run for the U.S. Senate was because of the health care law. I come from the private sector. I understand marketplaces. I understand what works and what does not work. And, I was very concerned about the very harmful effect, on real people, that the Patient Protection Affordable Care Act (ACA) would actually result in—and it is coming true.

The problem, that, certainly, I think all of us have had, in really evaluating the Patient Protection Affordable Care Act, is the complexity of the data. There is not just one overall metric that you can kind of point to and say, “Hey, it is not working.”

There are some metrics, I think, some pretty powerful ones. So, absent that very simplistic type of metric, evaluating the success or failure, I think, probably, the best way of doing it is the way you evaluate any kind of product or any kind of program. I come from the private sector. We do capital expenditure reviews. And, managers would say, “OK. This is what we expect, if we invest this kind of money.”

So, I think, maybe, the best way to take a look and start off the hearing—with my opening statement which, by the way, I have a

written statement. I would like to have that entered into the record¹—I will enter yours too—is, literally, to take a look at what promises were made and how those promises—were those promises fulfilled or not?

There were three primary promises made when people were considering, debating, discussing and, finally, passing the Patient Protection Affordable Care Act. The first one was pretty famous—and I will quote. This is from President Obama—and he made this promise 31 times: “If you like your health care plan, you will be able to keep your health care plan. Period.” You are going to be able to keep it.

Well, there are all kinds of figures, again. How many millions of Americans actually lost their health care plan? I have seen them as high as, maybe, 8 million, but let us be conservative and go with the Urban Institute’s numbers. Their most recent study said that about 2.6 million Americans lost their health insurance plans. In Wisconsin, certainly, we had something called the “high-risk pool.”

Anybody involved in the writing of the Patient Protection Affordable Care Act—they knew high-risk plans were going to be eliminated. So, I think there are more than 20,000 Wisconsinites that were in the “high-risk pool.” And, again, the authors of Obamacare—I will just start referring to the ACA as Obamacare—they knew those individuals were going to lose their health insurance plans.

Early on, I had a couple—this was actually in the fall of 2008—call me in a panic. His wife had Stage IV—I believe it was lung cancer. He was suffering and being treated for prostate cancer. They, obviously, were losing their “high-risk pool” plan. They were paying about \$700 a month—\$767 per month—for insurance in the “high-risk pool”, which is very competitive. That was a program that actually worked very well in Wisconsin.

First of all, they tried getting on healthcare.gov almost 40 times and could not, because that was a disaster when they first tried to initiate it. Finally, they called our office seeking help. Now, we did guide them to a couple of the insurance companies that were going to be on those exchanges. The cheapest plan they could find was \$1,400. But, again, that couple lost their health care plan—contrary to President Obama’s repeated promise that that would not happen.

The second guarantee, if you like—that means, again, I will quote President Obama: “That means that, no matter how we reform health care, we will keep this promise to the American people, this promise: If you like your doctor, you will be able to keep your doctor. Period.”

I do not think anybody would stand up and say that that has been true. People have lost their doctors. We have a couple, in Marinette, Wisconsin, who, obviously, have lost their doctor. And, I just want to read a quick quote here. The only plan they could afford, under Obamacare, meant they would lose the doctor they have had for over 15 years. And, their quote was, “Now I have to see a physician I have never even met.” Broken promise number two.

¹ The prepared statement of Senator Johnson appears in the Appendix on page 49.

I think the third most famous promise was—as a candidate, President Obama repeated: “In an Obama Administration, we will lower premiums by up to \$2,500, for a typical family, per year.” The truth is, back in 2008, when he was running as a candidate, according to the Kaiser Family Foundation (KFF), the average family was paying about \$12,680 per year. In the latest figure by the Kaiser Family Foundation, an average family is paying \$18,142 per year. That is a \$5,462 increase, since President Obama made that promise. That is about 43-percent.

You can look, year by year—and, obviously, that is the largest increase, because health care continued to increase—but even from 2013, the year before the implementation of Obamacare, it was \$16,351—and, today, it is \$18,142—and that is still a \$1,791 average increase across the board.

So, obviously, the average family has not seen a \$2,500 per year reduction in health care. Again, I have specific examples. A “Jan-ice”, from Spooner, Wisconsin, wrote me and said that, prior to Obamacare, she was paying \$276 per month for health care. Her latest quote was \$787 per month. That is a 185-percent increase.

And, we had a woman—a young woman who—a young mother—she was a nurse. Her husband operated in the heating, ventilation, and air conditioning (HVAC) industry. They both were working. They loved their jobs, but, because of the increase in premiums—they went from about \$500 per month to \$700 per month to \$1,200 per month—a \$700 increase. That is a 140-percent increase. The only way they could afford insurance—they were not getting it through their employer and they were having to buy on the individual market. The only way they could afford insurance was if she quit her job, so the income was lowered far enough that they could qualify for the subsidy. Broken promise number three.

The really sad part about this is that this was known. The people who supported Obamacare had to know that those promises could never be kept. And, I just want to quote a number of quotes by Jonathan Gruber, who was, certainly, one of the individuals involved in the authoring of Obamacare. Politifact called him “an architect”—and one of many architects of Obamacare—paid almost \$400,000 by the Administration to consult. He was talking about the Cadillac tax, and here is his quote. He said, “We just tax the insurance companies, they pass on higher prices that offset the tax break we get, and it ends up being the same thing.”

Here is really the important quote: “It is a very clever, basic exploitation of the lack of economic understanding of the American voter.”

He went on to talk about the Cadillac tax and said—again, this is Jonathan Gruber, one of the architects of Obamacare—somebody who knew what he was doing. He said, “Americans were too stupid to understand the difference.” He also said, “The lack of transparency is a huge political advantage,” and, basically, called the stupidity of the American voter or whatever—but, basically, said that that was really critical to getting the thing to pass.

Now, that is a pretty sad state of affairs, but that is the truth. That is what happened.

Now, I just wonder—I just kind of ask the question—we have some Agencies in the Federal Government—one set up under the

Dodd-Frank Wall Street Reform and Consumer Protection Act, called the Consumer Financial Protection Bureau (CFPB)—we also have the Federal Trade Commission (FTC)—that take a look at consumer fraud and try and protect the consumers. I wonder what they would do—the kind of enforcement action they would take against an insurance company that sold a product—an insurance product—and said, “Hey, listen, once you buy this thing, you are going to be able to renew this forever. If you like this plan, you can keep it.” And then, in the fine print said, “Well, that is not true.” In addition, they said, “Hey, this insurance plan allows you to keep your doctor. Period. You are going to be able to keep your doctor,” but then, the fine print said, “Well, not if that doctor is not part of the network that we are going to cover.”

Three, if you buy this health care plan—whatever you were paying last year—your premium is going to go down by \$2,500. And, instead, your premiums went up \$1,700 or \$5,000. I just wonder what these Federal Regulatory Agencies would do to an insurance company that engaged—and let me be very clear about what this Administration did. It was a massive consumer fraud. That is what it was. That is what Obamacare is: a massive consumer fraud. We are going to be taking a look at that today. And, during my questioning, I will, probably, be asking the Deputy Insurance Commissioner from Wisconsin kind of his thoughts on how we would handle that, in Wisconsin.

So, again, I want to thank the witnesses for coming. This should be a very interesting hearing. And, I think it is a very important hearing, because this Obamacare law is costing American taxpayers a whole lot of money. We all want people to be covered by health care. We all want people to have access and to be able to get high-quality insurance, but we did not have to completely remake the insurance in the health care market, to try and fill that gap and help those individuals, who we all want to help. And, I think we are going to see that this is not working. Those promises were, certainly, not lived up to.

And so, again, I want to thank the witnesses. And, I will turn it over to Ranking Member Senator Carper.

OPENING STATEMENT OF SENATOR CARPER¹

Senator CARPER. Thank you. Thank you very much, Mr. Chairman.

Welcome to one and all. Who of you is from Ohio? I am an Ohio State University (OSU) graduate, and I used to think Delaware was a little town just north of Columbus. I later found out it was a whole State. [Laughter.]

And, I moved there, and they let me be their Congressman, Treasurer, Governor, and Senator. And, I am sitting here, today, with my colleagues and am able to welcome you all here, today. Tell your Governor that I said hello. He is an old friend. Give him my best.

A little after noon, today, a handful of Senators—Democrats and Republicans, believe it or not—will gather in a room, not far from the Senate Floor—something we do almost every Thursday that we

¹The prepared statement of Senator Carper appears in the Appendix on page 51.

are in session. For, maybe, a half an hour or so, we take part in a Bible study, lead by a guy who used to be a Rear Admiral in the Navy. He is Chief of Chaplains, from Navy Marine Corps. His name is Barry Black. He is our Senate Chaplain today, and believe it or not, Democrats and Republicans—amazingly, sit there and read in the same room. We read the scripture, we pray together, we share things with each other, and we talk about all kinds of things.

And, invariably, during those conversations, Chaplain Black will ask how our faith should guide us. Almost every week—“How should our faith guide us in the work that we do here and at home?” It is a good question. It is a really good question.

And, almost every week, he reminds us of one of the two greatest commandments we have all heard. And, that is: “To love our neighbors as ourselves”—to treat other people the way we want to be treated. And, Chaplain Black often invokes Matthew 25 as well. You may not recognize that right away, but you will in a second, because Matthew 25 calls on us to focus on the least of these—the least of these in our communities. I am just going to paraphrase it today: When I was hungry, did you feed me? When I was naked, did you clothe me? When I was thirsty, did you get me to drink? When I was sick or in prison, did you visit me? When I was a stranger in your land, did you take me in?

Matthew 25 does not say, however, the following things. It does not say, “When my only source of health care was a crowded emergency room, did you help me?” Matthew 25 does not say, “When I turned 22 and could no longer be covered by my parents’ health care, were you there for me?” It does not say, “When I could no longer find health care coverage, because of a preexisting condition, did you do anything about it?” It does not say, “When I could not afford the medicine that would enable me to hold down a job or be the kind of parent that my children needed, did you lend a helping hand?” And, it does not say, “When I was denied health insurance, because I happened to be a woman, maybe, of childbearing age, and was charged an arm and leg for that coverage, did you go to bat for me?”

Most of us are people of faith—different faiths. I believe we all agree on one thing, and that is, we have an obligation to treat other people the way we want to be treated—and we also have an obligation to the least of these who live among us. I believe that. I think my colleagues believe that and I think most of the people in this room believe that. And, I would like to think that most of the people in our country believe that. And, because our Nation’s budget deficit, while down—it has been greatly reduced—it is still too large, we need to find ways to meet that moral responsibility to the least of these, in ways that are fiscally sustainable.

Just about every American President since Harry Truman has sought to find ways to do just that. They believed in their hearts that, when people in this country are sick or in need of health care, they ought to be able to see a doctor or nurse—or maybe both—within a reasonable period of time. And, I am certain that most, if not all, of our colleagues believe that—and I am sure that most Americans believe it as well.

So, why has it proved so hard to do? It sort of reminds me of what my mom and dad used to say to my sisters and me. They used to say, "The hardest things to do are the things most worth doing." This is a hard thing to do. This is a really hard thing to do.

For another—just about any time, we might—one of us might try to do something meaningful about it, our efforts can be turned into a 30-second commercial and used as political weapons against Presidents or Members of Congress who try to do what we all know, in our hearts, is the right thing to do.

Well, I will be the first to acknowledge that the Affordable Care Act is not perfect. I am not perfect—none of us are. I have never written a perfect law, and, my guess is, if truth be told, neither have my colleagues. This legislation—this law—can clearly be improved. When the election is over, we need to go to work to do just that—stop "carping" about it. "Carping" is one of my favorite verbs. Stop carping about it, and just go to work.

And, having said that, the Affordable Care Act has sought to better ensure health care for all Americans. I just want to mention a couple of ways how:

In part, by creating state-based health insurance marketplaces, where people, who may never before have had access to health care, now have the opportunity to choose a plan that helps them get healthy and stay that way. How? By participating in large purchasing pools—not unlike the ones that Federal employees have participated in for decades. The individual mandate that incents people to purchase these plans is a well-tailored incentive that helps these marketplaces grow and thrive, so that insurance companies are not left with a pool of people to insure that are largely older, sicker, and more expensive to insure.

In this room, today, there are witnesses and Members of Congress who represent—among others—the States of Delaware, Washington, Iowa, Ohio, Wisconsin, and more. The rate of people without insurance, in our States, on average, has fallen by almost half since our respective marketplaces have opened—almost half. For the Delawareans, Washingtonians, Ohioans, Iowans, and Wisconsinites who may now take the child to the doctor, it is not only life changing, it can also be live saving—and these life changing effects are not being felt only in our States. Today, because of the Affordable Care Act, 20 million Americans have access to health care that did not have it before—who did not have it before.

Our uninsured rate is less than 9-percent—an all time low. Americans now have access to free preventive services, like cancer screenings and yearly checkups. And, the vast majority of people in the marketplaces buy their health insurance for less than \$100 per month—less than \$100 per month. This progress has been realized, while extending, at the same time, the life of the Medicare Trust Fund by 11 years.

I find it more than a little ironic that we have been deadlocked in partisan fighting, for years now, over a law that—unknown to most—is actually built on a couple of sound Republican ideas: health insurance marketplaces and the individual mandate.

To my friends on the other side of the aisle—they are my friends—your willingness to walk away from the policies your party

once championed is dumbfounding to me, especially when those very same policies are enabling us to begin making a positive difference in the quality of life for so many Americans.

Just a quick refresher for those who may not recall, 2012 Republican Presidential nominee and former Massachusetts Governor, Mitt Romney, revolutionized health care in Massachusetts, by creating an insurance marketplace and requiring citizens to, eventually, obtain coverage. In fact, these ideas go back even further. Listen to this: In 1993, Republican Senator John Chafee introduced legislation that proposed an individual mandate and the establishment of insurance purchasing pools. That bill looked, frankly, a lot like the Affordable Care Act we are discussing at today's hearing. In fact, it had some 20 Republican cosponsors in the Senate. Some of them still serve here, today.

Fast forward to 2009, my first year as a member of the Senate Finance Committee and the first year of a new Administration. And, our new President called on Democrats and Republicans to try and achieve what previous Presidents talked about doing for more than half a century. But, instead of coming to the table pursuing a productive discussion about how we could expand access to health care for millions of Americans, in the end, Senate Republicans, sadly, chose not to engage. But, the President and the rest of us soldiered on and, finally, passed this historic law that all of us acknowledge is not perfect—but a good deal better than continuing to do nothing.

Like any major new Federal program, adjustments are going to need to be made as it is implemented. And, unfortunately, we have had a hard time finding as many willing partners in this effort as we would like. There used to be a time when Republicans and Democrats would come together to make bipartisan health care reforms. Some of us were here when we did just that. We created the Medicare Part D Prescription Drug Benefit. There was a lot of blowback on that. So, what did we do? We fixed it—we made it better.

When we created Medicare Advantage Plans, there was a lot of blowback on that too. What did we do? We fixed it—we made it better. And, we did that together.

That is not what we have done, with respect to the Affordable Care Act. Time and again, our Republican friends—and they are friends—have blocked funding, proper implementation, and, I think, common sense improvements. Republican Governors and State legislators in 19 States have refused to expand Medicaid—not Ohio Governor, John Kasich—tell him I said that—leaving millions of Americans without coverage and increasing marketplace premiums for millions more.

It is a sad state of affairs when it seems that, sometimes, the only health care votes we are allowed to make are the ones which repeal the Affordable Health Care Act completely, leaving nothing in its place and leaving Americans with nothing—nowhere to turn besides a hospital Emergency Room (ER). I will close with these words.

In a couple of months, thankfully, Americans will go to the polls to elect a new President and new Members of Congress. I talk almost every day with Delawareans who wait with anticipation for

that day to arrive. Some of my colleagues feel that way, too. Once that day has arrived, though, and the new Congress—as well as the new President—have taken their oaths, we need to go to work to make a good idea even better. Like we did with Part D and like we did with Medicare Advantage Plans. We can do that. We need to embrace what I call the three Cs: communicate, compromise, and collaborate. We also need to embrace the words in the preamble of our Constitution. Remember, it starts off, “We the people of the United States, in order to form a more perfect union.”

And, we need to get to work making the Affordable Care Act better. We can do that. I know we can and, with the right leadership, I believe that we will. In doing so, we will have, in the words of Mark Twain, “Confounded our enemies and amazed our friends.” Let us roll.

Chairman JOHNSON. Thank you, Senator Carper.

By the way, it is 54 days until Election Day, but who is keeping track? [Laughter.]

Chairman McCain is stepping away from the Senate Armed Services Committee (SASC) hearing, and he would like to say a few words. So, we will go ahead and do that.

OPENING STATEMENT OF SENATOR MCCAIN

Senator MCCAIN. Thank you, Mr. Chairman. And, I would appreciate if my complete statement would be made a part of the record.¹

And, I must say that I was entertained by the statement of my dear friend from Delaware—and we are very dear friends—but to, somehow, now call upon Republicans to work with you to fix this disaster after—on the Floor of the U.S. Senate—you did not allow a single Amendment—not a single Amendment by the Republicans was allowed. It is the first time an entitlement program has ever been enacted on a strictly partisan basis.

You had your 60 votes. You rammed the 60 votes, and the Affordable Care Act, down our throats. And so, now that it has been an abysmal failure, you want us to come and help you to bail it out. We want to replace it. We do not want to fix it. We want to replace it, because it has been a complete failure—and my State is, probably, the best example that I know of.

We now have 14 of our 15 counties with—guess what?—one provider. Do you remember the statement, “If you like your doctor, you will be able to keep your doctor. Period. If you like your health plan, you will be able to keep your health care plan. Period. No one will take it away, no matter what.”

Of course, that turned out to be a lie. Ever since, Americans have been hit by broken promise after broken promise and met with higher costs, fewer choices, greater uncertainty, and poorer quality of care—and, let me tell you, my home State of Arizona is hurt.

We are talking about, next November 1, seeing as much as 65-percent increases in premiums for our average citizens. We are talking about young people, who are now opting, clearly, to pay a fine, rather than to see these dramatically increasing costs—and,

¹The prepared statement of Senator McCain appears in the Appendix on page 54.

of course, the cost of health care continues to skyrocket—all done on a purely partisan basis.

I remember the victory dance that you guys performed after passing Obamacare without a single Republican vote. And so, now the chickens have come home to roost. So, now, the question is: “Will the Republicans not join with us and fix this problem?”

Give me a break. We need to replace it. We need to fix it and we need to go back to the fundamental principles of economics, which do not involve taking money from healthy young people in order to take care of unhealthy older people. That was the fundamental broken premise. And now, of course, I guarantee you the next step will be that you guys are going to want to go to a government run health care system. That will be your answer—which is, in Europe, clearly, a two-tiered system between those who are wealthy and can afford their own health care and those who are not, who will have a substandard level of care.

Mr. Chairman, I would like to have my statement included in the record—but the people in my State are hurting. The people in my State are hurting. We have 15 counties—in 14 of them, there is only one provider. Just for a period of time, we had a county with no provider. Now, Blue Cross Blue Shield (BCBS) has moved in. Is what is happening in my State—is that, “If you like your policy, you can keep your policy? If you like your doctor, you will be able to keep your doctor? Period. No one will take away your health care.”

Of course, we have people scrambling all of the time as, understandably, these providers have hundreds of millions of dollars in losses. They cannot afford to stay in this affordable health care business.

So, I thank you for holding this hearing. I thank the witnesses. And, if the Senator from Delaware and his Democrat friends want to join together with us, then yes, let us throw it where it belongs: in the trash can. And, let us start all over and give people an affordable health care system that they can live with and that will not be the situation that exists in my home State of Arizona.

I thank you, Mr. Chairman.

Chairman JOHNSON. Thank you, Senator McCain.

It is the tradition of this Committee to swear in witnesses. So, if you will all rise and raise your right hand.

Do you swear the testimony you will give before this Committee will be the truth, the whole truth, and nothing but the truth so help you, God?

Ms. TAYLOR. I do.

Mr. WIESKE. I do.

Mr. GERHART. I do.

Mr. KREIDLER. I do.

Chairman JOHNSON. Thank you. Please be seated.

I think our first witness is Lieutenant Governor Mary Taylor—I think Senator Portman would like to introduce the Lieutenant Governor.

OPENING STATEMENT OF SENATOR PORTMAN

Senator PORTMAN. Thank you, Mr. Chairman. And, I am really thankful we have Mary Taylor with us, because she is a true ex-

pert. She is a certified public accountant (CPA), first, and had 16 years in the private sector before she decided she wanted to get into public service. She started on her city council, where she did a terrific job—so much so that she got elected to the Ohio Statehouse. And then, she became our State Auditor—the first State Auditor ever to be a CPA. She transformed that office and was acknowledged, nationally, as having put together a cutting edge, 21st Century auditing office, in Ohio.

Then, in 2011, she was sworn in as our Lieutenant Governor of Ohio. She has two other jobs: One is on regulation. She heads what is called the “Common Sense Initiative”, which deals with making our regulations smarter—which has been a big reason for Ohio’s economic success during the Kasich-Taylor Administration. And then, second, she is the Director of the Ohio Department of Insurance (ODI).

So, here you have a CPA with this private sector background and government background, who, actually, is in charge of our Ohio Department of Insurance and, therefore, has gotten very involved in the Affordable Care Act.

You are going to hear from her on this. She has some really interesting statistics—very specific numbers as to what is happening with our premiums, by the way. For the individual market, it has gone up about 91 percent. With regard to the Obamacare exchanges, I believe the number is a 13-percent increase next year. Who can afford that?

And so, she will have the opportunity to talk a little bit about what is actually happening in our health care market, in Ohio—what it was like before the Affordable Care Act and what has happened since. So, I am really glad she is here. And, thank you for letting me introduce my friend, Mary Taylor.

Chairman JOHNSON. Lieutenant Governor, by the way, I knew there was something I liked about you—fellow accountant.

So, Lieutenant Governor.

TESTIMONY OF THE HONORABLE MARY TAYLOR,¹ LIEUTENANT GOVERNOR, AND DIRECTOR, OHIO DEPARTMENT OF INSURANCE, STATE OF OHIO

Ms. TAYLOR. Thank you very much, Chairman Johnson, Ranking Member Carper, and distinguished Members of the Committee. Thank you for the opportunity to testify before the Senate Homeland Security and Governmental Affairs Committee (HSGAC).

My name is Mary Taylor, and I am Lieutenant Governor of Ohio, as well as the Director of the Ohio Department of Insurance. Today, I will provide testimony regarding Ohio’s experience, related to the Affordable Care Act, specifically, in regard to premium changes, market shifts, and other trends, since 2013.

As the Director of the Ohio Department of Insurance, I am responsible for regulating Ohio’s insurance market—the seventh largest in the United States. Ohio is home to more than 200 insurance companies, and more than 1,600 do business in the State, representing \$76 billion in annual premiums.

¹ The prepared statement of Ms. Taylor appears in the Appendix on page 57.

For years, we have taken great pride in the competitive insurance market we have in Ohio, across all lines of insurance. Under the leadership of both Democrat and Republican Administrations, the Ohio Department of Insurance has been a fair and thoughtful regulatory agency, providing the certainty and predictability that industry is looking for to be successful, which, in turn, benefits consumers. In fact, because our market is so competitive, the most recent data shows Ohio's auto and homeowners insurance premiums are below the national average and are ranked 12th and 9th.

But, I am here today to focus on health insurance and what is happening in Ohio. Prior to the implementation of the ACA, Ohioans benefited from a large selection of insurance carriers, with more than 60 companies selling health insurance products in Ohio. Consumers could buy plans with a wide variety of coverage options and pay the corresponding premiums to go with that coverage.

Unfortunately, since before the law was implemented, I and many others across the country—including Members of this Committee—pointed out that the ACA would not work as promised. Studies conducted in Ohio, at my request, showed premiums would go up, consumers would lose choice, and the market would suffer from turbulent and disruptive changes. Fast forward to today and the new ACA era we live in.

In 2016, 17 health insurers sold products on Ohio's Federal exchange, during open enrollment. Next year—in 2017—assuming all companies approved to sell on the exchange by the Ohio Department of Insurance enter into contracts with the Department of Health and Human Services (HHS)—only 11 companies will offer exchange products. This dramatic decrease in participation can be better put into perspective when looking at a county-by-county comparison in Ohio.

In 2016, every one of Ohio's 88 counties had at least four insurers selling exchange products during open enrollment. In 2017, 19 counties will have just one insurer selling exchange products and 28 counties will have just two.

Fewer options give consumers less of an opportunity to get the coverage they need. Dramatically increasing premiums make the problem even worse. Based on the final rates approved for 2017, the average premiums, for individuals buying on Ohio's Federally-run exchange—as Senator Portman has said—have gone up 91-percent since 2013. Even as insurers have fled the exchange, recent statements from HHS indicate everything is fine. Premiums around the country are increasing, but the response is that consumers are being shielded by tax subsidies that will offset the costs. The cost of those subsidies will continue to rise as premiums continue to increase—and the American taxpayer must shoulder that burden.

I think most of us agree Americans should be able to purchase health insurance without facing barriers because of preexisting conditions. We agree more can be done to improve the system in order to increase accessibility and promote better outcomes for patients. However, the ACA is not living up to the promises that were made.

In Ohio, less than 250,000 people purchased health insurance through the Federally-run exchange in 2016. If you consider the

fact that there are 11.6 million people living in Ohio, that means we have completely upended the health insurance market, forced consumers to buy coverage they do not want or need, and placed significant regulatory burdens on job creators—all to offer taxpayer-backed insurance to 2.15 percent of our population.

We need to increase access by reducing costs—instead of forcing everyone to buy more expensive coverage that, in many cases, they do not need and they do not want. We need to empower States to design systems that are best suited for their populations—instead of forcing one-size-fits-all mandates across the country. We need to decentralize the powers in Washington that, quite frankly, do not understand insurance or how to regulate it—as my colleagues and my predecessors across the country do.

In Ohio, we have ideas to help improve our health system, without destroying the free market—as the ACA has done. We believe there is a better, more inclusive way to design reforms that will increase access without driving up costs, but we need the flexibility to do it. It is my hope that, with the help of Congress, States can once again have the power to implement positive change.

Thank you for the opportunity to testify before the Committee today. I would be happy to answer questions, Chairman, when you choose.

Chairman JOHNSON. Thank you, Lieutenant Governor.

Our next witness is J.P. Wieske. Mr. Wieske is Deputy Insurance Commissioner for the—can I say the great State of Wisconsin here, in the hearing?—I think I can—the great State of Wisconsin. He has served as Deputy Insurance Commissioner since 2016. Prior to his appointment as Deputy Insurance Commissioner, Mr. Wieske served as the Office of the Commissioner of Insurance's (OCI's) Legislative Liaison and Public Information Officer. Mr. Wieske.

TESTIMONY OF J.P. WIESKE,¹ DEPUTY COMMISSIONER, OFFICE OF THE COMMISSIONER OF INSURANCE, STATE OF WISCONSIN

Mr. WIESKE. Thank you, Chairman Johnson, Ranking Member Carper, and the distinguished Members of the Committee.

Last week, at church, the prodigal son was a parable that was discussed—as well as the parable of the lost sheep. And, I think, one of the concerns that we have, as we look at our insurance market, is that, in Wisconsin, we did, in fact, take care of the lost sheep. We did, in fact, take care of our folks.

You highlighted our “high-risk pool”, and our “high-risk pool” provided excellent care for the sickest among Wisconsinites. It provided subsidies for the sickest as well as those who had significant medical conditions—and they could choose any doctor.

Unfortunately, Obamacare ended that. That was 20,000 people that were thrown into the marketplace, which created additional problems. In our market, the individual market has grown to 272,000 people from 200,000 people. However, the 200,000 we had in the market prior to this did not include our “high-risk pool” and did not include our folks that were in our existing Medicaid program, where Wisconsin had, in fact, expanded it beyond the Fed-

¹ The prepared statement of Mr. Wieske appears in the Appendix on page 72.

eral requirements. In addition, we had a number of the reforms in Wisconsin, so we did not need the passage of Obamacare to protect adult dependents.

In fact, we had to move our adult dependent coverage requirement down to age 26, because we had expanded it to age 27, in the State of Wisconsin.

Our small-group market has dropped by 30,000 people since Obamacare—2013 to 2015. Our large-group market has dropped from almost 1.25 million people down to 1 million people. Now, most of that large-group market has moved into the Employee Retirement Income Security Act of 1974 (ERISA) space—the largely State unregulated space. So, I think we have a number of concerns with the way our market has been hit.

On top of that, we have seen a number of frustrations, from a consumer standpoint, regarding the rollout of Obamacare as well as the continuing problems for consumers, as we continue to regulate this market. So, we actually had to delay the end of our “high-risk pool” by several months, because of the disastrous rollout. We had to delay the movement of folks off of the Medicaid program into private coverage, because of the disastrous rollout.

On top of that, we are, consistently, getting calls from consumers—and consumer complaints, submitted to our consumer complaints division, talk about the interference of the health care exchanges for folks with their private coverage. Specifically, when people want to terminate their coverage, when they want to make changes, or when they want to add folks to their insurance plan, they no longer are able to just do that and to call the insurance company to make those changes. They have to call a Federal bureaucrat and ask for permission in order to get that done. And, that takes time—and it creates errors and it creates problems.

So, we have seen a number of regulatory issues. In fact, last year—I will highlight one other issue—we had a consumer—an insurer contact us when the Federal Government asked them to take money out of all of their consumer accounts. They had made a mistake—and they had undercharged consumers—and, at Christmastime, the Federal Government had ordered them—which they would not do in writing—to take money out of the accounts of these consumers and pull it out of their accounts, in order to pay the back premiums.

Now, as a matter of course, insurance regulators do not let insurance companies charge back consumers when they have undercharged them. So, we actually had to issue an order to protect our consumers—to prevent the direct pulling of the bank account information, from consumers, at Christmastime.

On top of that, we are seeing, in this next year, this automatic reenrollment process, which is illegal in the State of Wisconsin. We have indicated, in letters, that it is illegal in the State of Wisconsin. We have 64,000 people in the State who will be losing their coverage—not just because of market withdrawals, but because of service area changes. Those 64,000 people will be automatically reenrolled—their information sent to another carrier without their permission. Their private information will be sent to another private medical insurer—from one to the other—without their permission, by the Federal Government.

It is going to be a, potentially, fraudulent and problematic area for our Wisconsin consumers—64,000 of them, potentially, who could see these numbers change.

In short, we have seen a number of issues, in the State of Wisconsin. And, we felt we did an excellent job of protecting consumers, prior to the ACA. We continue to try to protect them from the damage of the ACA. When we roll into 2017—I want to highlight that there will be, approximately, 200,000 people that will be newly on Obamacare—that have not been on it—who are on transitional plans, in our State. So, the damage is not yet done.

In short, Wisconsin believes that the damage of Obamacare, hopefully, is not permanent. And, we are hoping for a solution that moves this problem back to the States, for us to fix it.

Thank you.

Chairman JOHNSON. Thank you, Mr. Wieske.

I believe Senator Ernst would like to introduce our next witness.

OPENING STATEMENT OF SENATOR ERNST

Senator ERNST. Thank you, Mr. Chairman.

It is my honor to introduce to the Committee, today, Iowa Insurance Commissioner Nick Gerhart. Nick has served our great State as Commissioner since February 2013. And, we appreciate your service, Commissioner.

And, he also serves on the National Association of Insurance Commissioners' (NAIC) Executive Committee. The Commissioner's legal and health administration credentials, as well as his professional background, make him an excellent witness for us, today, to talk about this important topic. And, thank you, Commissioner, for traveling to Washington, D.C. to share your expertise with this Committee and the audience members—and your perspective on Iowa's health insurance market.

Thank you, Mr. Commissioner.

Senator ERNST. Thank you, Mr. Chairman.

TESTIMONY OF NICK GERHART,¹ COMMISSIONER, IOWA INSURANCE DIVISION, STATE OF IOWA

Mr. GERHART. Good morning, Chairman Johnson, Ranking Member Carper, and esteemed Members of the Committee. It is an honor to be here to share our views, in the State of Iowa.

I really want to focus just on a couple of things in my short time. I want to focus on the duty of an insurance commissioner, the rates, and what is happening at the kitchen table to members of our State—and really a couple of highlights to fix some of these issues. And, I did submit written testimony, which is much longer, outlining some of those potential fixes.

As the Insurance Commissioner for the State of Iowa—we are pretty local—a State of three million people. So, we actually know the folks that these rate increases are impacting. So, the 75,000 Iowans that are getting rate increases of up to 43 percent—I know a lot of these folks. I see them at church and I see them in the grocery store—and a lot of them are friends. In fact, I want to share a story of a good friend of mine. He had a good corporate job. He

¹The prepared statement of Mr. Gerhart appears in the Appendix on page 79.

left that job. His name is Gregory Bailey. He started a company called Denim Labs in Des Moines, Iowa. He has two children in third grade and second grade and a lovely wife. And, when he got his notice, he called me—because he knows me—and was not very happy, obviously.

I hope we are still friends, but, at the end of the day, he understands what is happening here—and he and his wife are looking at making a significant decision around whether they downsize their home—go without coverage. So, these are impacting all of our constituents. I hope we can have a productive dialogue on some potential fixes.

In our State, we recently approved rate increases, from 19 percent up to 43 percent, impacting almost 75,000 Iowans. In a State of three million people, that is a pretty significant number of Iowans that this is going to impact. Cumulatively, the rates have been up about 100 percent since the implementation of the ACA. And, I am not here to say it was working that great before. Rates were going up before as well, but I think we have some ideas and solutions to make it better.

What we are seeing is a very high concentration of risk in this “individual-risk pool.” We had a “high-risk pool” that was functioning pretty well as well. We have expanded Medicaid, but a lot of the folks in this population are a lot like the Medicaid population. So, we have commercial insurers working to insure some of these “Medicaid-type population” folks. And, to give you an example, one claim in Wellmark is generating about \$18 million in costs. Even with the discounts for the providers, it is about \$12 million. That one claim is 10 percent of the 43-percent increase. So, that one claim in that risk pool costs about \$808 per member of that risk pool. So, you can see there is really no protection from that kind of a catastrophic claim. And, I will tell you that that claim, in a few of our smaller regional carriers, would make them almost insolvent.

Unfortunately, in Iowa, we have also experienced withdrawals from the market—United Health Group. We were the first State that had to take over one of the failed co-ops. On Christmas Eve—Day, 2014, we had to take over a co-op—the first one to fail. So, that caused a lot of disruption as well for the 120,000 members in Iowa and Nebraska.

So, folks are a little bit skeptical right now about the market. We will have 23 counties, I believe, with one provider. We will have about half of the counties with two providers in the exchange. So, there are issues of having less choice.

The product that is seeing the most traction in the market is what is termed a “narrow network” product. So, you have a concentration with one group of doctors that you could use—and, again, those plans are fine. I think my family would buy one if we had the option of buying one, but it is a “narrow network” plan. But, we have deemed those to be appropriate and we are waiting for the Centers for Medicare and Medicaid Services (CMS).

But, as Lieutenant Governor Taylor said, we really do not know who is going to sign on, on the 23rd of this month, to be in the exchange—or not. We will know that here in a couple of weeks, I guess.

I also want to kind of highlight a few fixes. We talked a little bit about the “three Rs” in my written testimony: The risk corridor, risk adjustment, and reinsurance. Risk corridor sunsets—I would think we would want to keep it that way. It did not work very well. Risk adjustment—there are some new rules that CMS recently put out. I think that those, at least, look encouraging. And, I will wait for the carriers to comment on that. But, the reinsurance does sunset and we think that that was a provision that actually worked pretty well. And, it did help stabilize the market a little bit.

Finally, we would encourage the Committee and the Members of this body to look at this idea of “high-risk pools” and, maybe, push the issue back to the States. We are going to look at a Section 1332 State Innovation Waiver, potentially, to try to create an Iowa-based solution for Iowans. We think that is the best way to do it. Because, if you have seen one health insurance market, you have, probably, seen one health insurance market, to be honest with you—and our issues are not what Washington, Texas, Wisconsin, or Ohio would have. So, we feel that pushing it back to the States—for them to have more control makes a lot of sense.

So, I would like to conclude by saying that it is an honor to be with you all. I will answer any questions at the right time. Thank you.

Chairman JOHNSON. Thank you, Commissioner.

Our final witness is the Honorable Mike Kreidler. Mr. Kreidler served as the Insurance Commissioner of the State of Washington. He has served as Washington State’s Insurance Commissioner since the year 2000. Mr. Kreidler previously served in the U.S. House of Representatives, representing Washington’s 9th Congressional District. Congressman Kreidler.

TESTIMONY OF THE HONORABLE MIKE KREIDLER,¹ COMMISSIONER, OFFICE OF THE INSURANCE COMMISSIONER, STATE OF WASHINGTON

Mr. KREIDLER. Thank you very much, Chairman Johnson, Ranking Member Carper, and Members of the Committee.

I am the longest serving Insurance Commissioner in the country, currently. And, it is a position—that means that I have served 10 years before the Affordable Care Act and 6 years now, after. And, because it is the law of land, I have been working diligently to implement it to the fullest extent possible, in the State of Washington.

I can tell you that, even though we have heard different stories, it has, quite frankly, had a profoundly positive impact on the State of Washington—not without problems, but profoundly—overall, very positive. And, we really need to look back at what it was like in that environment before health care reform.

We have approximately seven million people in the State of Washington. Nearly a million of them were uninsured. That was 14-percent of the population. We were experiencing something like \$2 billion a year in uncompensated care. That is care that is being paid for, but it is coming at the expense of other payors that are absorbing those costs.

¹ The prepared statement of Mr. Kreidler appears in the Appendix on page 86.

We also had a robust market at that time, before the Affordable Care Act—some 11 insurers in the individual markets. But, if you looked at the products out there, none of them in the individual market covered maternity or covered prescription drugs. And, for many people, they would find that a serious shortcoming.

Today, we are down to 7.3 percent of the population being uninsured. That is, nearly, a 50-percent drop since the Affordable Care Act came into effect. And, we have taken the \$2.3 billion in uncompensated care and dropped it down to \$1.2 billion. Almost 80 percent of the people inside of our exchange—and we are looking at, approximately, 170,000 people inside of the exchange. The comparable number on the outside—but, of those inside of the exchange, 80 percent of them now receive a subsidy.

Today, we are looking at—for 2017, 13 insurers in the market and 154 plans that will be offered to consumers, for 2017. The rates that came in were higher than what we had anticipated at 13.5 percent—their request—not what I have approved. In October, we will know better about what that final number will be, but it is higher—and it is, certainly, something that was not unexpected.

When insurers started, in 2013, to submit their plans, they had no idea just exactly what they should wind up charging. It was a dramatic change. As I said, now they cover maternity and drugs, and they did not before. So, it was a real change. So, they are still in kind of a learning phase here, but double-digit rate increases are no surprise. It is, certainly, something we saw very commonly—much more so before the Affordable Care Act. And, in 2014, as I said, it was really just a guess, at that point in time.

And, no one wants to see rate increases going forward—least of all if you are elected statewide, like I am, and have to do it and have to have direct accountability to the people of the State of Washington.

I think one of the things we really look at is the kind of changes that are going forward, as Commissioner Gerhart was talking about. One of those things, if we want to make it work better, that I would identify is, we have to make sure that premium relief to consumers is something that is there—and, perhaps, even more so than what we have currently. We also need to stabilize the health insurance markets going forward.

The number one task for us was to get everybody covered. That was the first step. The second step, which is critically important is, we have to do a much better job of helping to hold down health care costs. As I look at changes that could make a profound difference in helping to stabilize that health insurance market, one of them would, certainly, be to help hold down the cost increases we are seeing in prescription drugs. That is the number one driver, right now, in the plans that came forward to us for 2017.

Another, from a national perspective, is to make sure those 19 States that have not expanded Medicaid do so. In the State of Washington, we have 595,000 people that are now insured, who, previously, did not have health insurance through the Medicaid program.

I would also say that we have to make sure that those States that have nonconforming plans out there—so you have a breakup of the risk pool by virtue of nonconforming plans and conforming

plans to the Affordable Care Act—they all need to meet that same standard. Washington is working, as I said, diligently, to make sure that we fully embrace the Affordable Care Act reforms and to provide those to the people of the State of Washington.

Now, holding down premiums is the next big factor needed to stabilize the private market. Immediate steps need to be taken to accomplish this. If we want to make this sustainable in the future, we have to address that second part: Get them covered, first, and, second, stabilize the market.

Thank you, Mr. Chairman.

Chairman JOHNSON. Thank you, Mr. Kreidler.

Let me start with you. You said that it is an 18-percent increase that has been requested, on average?

Mr. KREIDLER. 13.5 percent.

Chairman JOHNSON. 13.5 percent. OK. You said that that was not unexpected—no surprise. Again, you were asserting that position. You heard candidate Obama say that his health care plan would reduce premiums by \$2,500 per family. Did you believe that?

Mr. KREIDLER. I have to admit there were a number of claims that were made, during those discussions, that I did not, as a professional regulator, necessarily embrace in totality.

Chairman JOHNSON. Commissioner Wieske, it is very difficult to try to figure out exactly what these average increases are. And, I know the Manhattan Institute for Policy Research has done kind of a national study, by State. I have looked at that—six different demographic groups, in the State of Wisconsin. Our biggest cost increase, in terms of the individual Obamacare market, was in the first year. But, as I put the numbers together, based on the expected increase again for this year, the lowest increase on one of those demographic groups, since the inception of Obamacare, is about 1.8 times—in other words, an 80-percent increase. So, if you were paying a buck, now you are paying \$1.80 for your health care coverage. The highest is over \$3.00.

I want to get to the point, in terms of what would happen, in the State of Wisconsin. I kind of raised the issue, on a national level, with the CFPB or the FTC. In the Office of the Commissioner, what would you do? Because, I know we have laws, in Wisconsin, where you are authorized to bring enforcement proceedings against insurers that engage in unfair marketing practices. By the way, that is defined as “misrepresentations or unfair inducements”, which, I guess, a tax penalty would be kind of an unfair inducement. “Unfair discrimination.” I do not know about that. What about the restraint of competition? I think Obamacare is definitely restraining competition. “Unfair restriction of contracting parties’ choice of insurer.” Well, we have definitely seen that and then extra charges—things like the Cadillac tax—attempt to unduly influence employers and unfair use of official position. Man, that really describes Obamacare. Right?

So, again, going back to the question I asked, if there is an insurance company that made those claims—you like your health care plan, your doctor, and \$2,500 reduction—what would you do, as Deputy Insurance Commissioner in the State of Wisconsin?

Mr. WIESKE. So, I think there would be a couple of things. So, first, up front, I do not know that we would let the insurer do that,

because they would go insolvent, because they would not be able to meet their obligations. Those promises are not deliverable. And so, I think we would have a concern if the insurer filed those with us.

If they filed them from an advertising standpoint, I think, we would consider that unfair trade practices—and we have concerns and we take action against the insurer, because those are promises that, obviously, an individual insurer cannot deliver.

We did have a number of carriers that wanted to make some sort of promises on rights over time. And, in fact, we did not allow them to do that. We have done that over a number of years.

Chairman JOHNSON. So, unfair trade practices—another term for that would be “consumer fraud”?

Mr. WIESKE. It would be a fraudulent advertising.

Chairman JOHNSON. In the private sector, that is unlawful, right?

Mr. WIESKE. Right. Correct.

Chairman JOHNSON. But, I guess when it is passed by the Federal Government—I guess that becomes legal consumer fraud.

Mr. WIESKE. It appears so.

Chairman JOHNSON. I really want to get back, because I was kind of shocked by a couple of your stories here. Describe again how the Federal Government forced you to recover undercharged premiums.

Mr. WIESKE. So, there was a particular insurer—and we actually have the order that we can get you a copy of. A particular insurer made a mistake in their rate system. So, their quoting system was correct, but the rate system was incorrect. When the people got the rates and they were charged, a lower amount was pulled out of their accounts.

Chairman JOHNSON. Just stop. So, again, had that just occurred with a private company, would that private company have been allowed to go back in and pull money automatically out of those accounts?

Mr. WIESKE. They would not have even asked. They would not have asked us to pull money out.

Chairman JOHNSON. They would have just sucked it up and said, “We made a mistake.”

Mr. WIESKE. They would have expected—most companies are good companies. From the consumers—they would not expect that—and they certainly would not ask their regulator if they could go back 6 to 8 months and pull money out of consumers’ accounts. No, they would not even ask that question.

Chairman JOHNSON. I also want to talk about automatic enrollment.

Mr. WIESKE. Yes.

Chairman JOHNSON. When I first got involved in this, I called ACA—Obamacare—the greatest assault on our freedoms in a lifetime. This certainly speaks to that.

Talk exactly about what is going to happen to individuals without their approval. What is going to happen, exactly, with automatic enroll?

Mr. WIESKE. So, a consumer, who is currently in a plan with a health insurer that is either exiting a particular service area or

exiting the market in its entirety, will have their information sent by an insurer chosen—they have the option to choose it, by the way, but an insurer chosen by the Federal Government, and enrolled in that plan that will get an 834 transaction—is our understanding. And so, that information will be sent to the insurer, who will then contact the consumer and ask them for premium.

Chairman JOHNSON. Now, are there not laws against unauthorized transfer of medical information from one party to another?

Mr. WIESKE. We have made that argument, too. We have made that argument to our good friends in the Federal Government. We sent a letter over to Kevin Counihan, indicating all of the legal arguments—including Federal laws that we feel are broken—in sending people's private medical information—private information from one insurer—and financial information, by the way—from one insurer—private insurer to another private insurer.

Chairman JOHNSON. So, without the coercion of the Federal Government, an insurer would not be allowed to pass that information to another insurer without the insured's permission, correct?

Mr. WIESKE. Absolutely not.

Chairman JOHNSON. That insurer would be breaking the law.

Mr. WIESKE. Absolutely.

Chairman JOHNSON. So, once again, this is legal?

Mr. WIESKE. Well, we do not think it is legal.

Chairman JOHNSON. Well, I am just saying, the Federal Government—

Mr. WIESKE. But they are treating it as—

Chairman JOHNSON [continuing]. The Federal Government is doing their—

Mr. WIESKE. Correct.

Chairman JOHNSON. They are doing it on their own account.

Mr. WIESKE. Correct.

Chairman JOHNSON. Wow.

Lieutenant Governor Taylor, I want to talk a little bit about the reduction in choice, because it is pretty stark—60 companies down to 11. That was not supposed to happen under the ACA, was it? I mean—competition was supposed to flourish, right?

Again, I am coming from the free market. I would have loved to have been a monopolist, because I had to compete. My prices are lower, my quality is higher, and my level of customer service is higher because of competition. But, competition is best realized when you have a lot of competitors. That is not what is happening here. We are seeing consolidation in the health care industry, across the board, but, in your State, you certainly have an example of that.

Ms. TAYLOR. Absolutely, Mr. Chairman.

Unfortunately, we are seeing consolidation. Nationwide, of course, we know there are a couple of cases pending, regarding mergers of large insurance companies. But, even more than that, when you look at who is still left in the market, selling on the Federal exchange, in Ohio—as you have already stated, we had 60 companies that, prior to the ACA, you could choose from—any individual could choose to purchase their insurance from—versus—we are going into 2017 down to 11. And, I think that is what is—again, which I stated in my testimony—the even starker reality

is evident when you look county by county. I spent all day yesterday, primarily, in Zanesville, which is Muskingham County in Ohio. And, they are one of the counties that will have one insurer. So, I do not call that a choice. That is one insurer.

Chairman JOHNSON. It is not competition.

Ms. TAYLOR. No. And, to a person—I met with a lot of people and a variety of audiences and crowds, and it seemed to me that everyone knew that that was what was going to happen under Obamacare starting in 2017. They are very concerned. In fact, one gentleman asked me, “Is there not something that you can do or your national association,” which we are all members of—and, unfortunately, no. The answer is no.

Chairman JOHNSON. I think you mentioned in your testimony—do you have an overall average amount that your insurance has increased since Obamacare?

Ms. TAYLOR. Ninety-one percent.

Chairman JOHNSON. Ninety-one percent. Senator Carper.

Senator CARPER. Thank you, Mr. Chairman.

Let me just start by saying a number of States—many States, maybe, as demonstrated by the Commissioner of Washington today, have fully embraced the health care law and have seen very significant benefits for most of their residents.

I request that statements from insurance commissioners, market leaders, and health secretaries from several States, including Rhode Island, California, Virginia, and Delaware, are entered into the hearing record.¹ I think all of these—and I would make that request, Mr. Chairman.

Chairman JOHNSON. Without objection.

Senator CARPER. Thank you.

All of these statements make, maybe, two points—and I will just briefly state them. One point is, the Affordable Care Act is working in their States, lowering the uninsured rate and improving their insurance marketplaces.

The second point that would be made in the statements is, Medicaid expansion has been critical to lowering the cost of private insurance and improving the health of their residents. That is a point I do not think we have made very well here, today. And, I will return to that later.

A little bit later, I am going to respond to some of what my friend Senator McCain said, but I will hold off on that for now.

Let me just ask a couple of questions, if I could, of Commissioner Kreidler. And, let me just ask what—first of all, congratulations on being the longest serving insurance commissioner in the country. Is that right?

Mr. KREIDLER. That is correct.

Senator CARPER. Pretty amazing.

What percentage of your population was uninsured before 2010, when the Affordable Care Act was first passed? Any idea?

Mr. KREIDLER. Yes. At that time—and as we look back over at least a decade or two that we have the information for—at the time of the passage, we were at 14 percent. We have reduced that down

¹ The statements submitted appear in the Appendix starting on page 90.

by nearly a 50 percent reduction in the number of uninsured in the State of Washington. It has had a profound positive effect.

Senator CARPER. All right. Thank you. Were individuals with preexisting conditions able to purchase comprehensive and reliable health insurance for a reasonable cost?

Mr. KREIDLER. No. They were not able to purchase it. There was the “high-risk pool” that was available to them, but there was a preexisting condition waiting period. So, if you had been diagnosed with cancer, and you would like to treat it right away, you would have to wait up to a year before you would have coverage.

Senator CARPER. In those days, were women charged more for insurance based on their gender? And, if so, any idea by how much?

Mr. KREIDLER. Actually, in the State of Washington, we have a State law that prohibits it—unlike a number of other States. So, there could not be a difference in the rates charged between men and women.

Senator CARPER. OK. My Republican colleagues, several of them, have recently introduced legislation to roll back the individual mandate. If enacted, how would this change affect the risk pools and health insurance premiums in your State?

Mr. KREIDLER. Well, it would devastate those pools, because you would have the healthy holding out until they got sick and then opting in—or hoping they could—when they started to become ill. If they, of course, had an emergent type of medical treatment, they are in a real problem until open enrollment rolls around again.

For the rest of the individuals, it would be a situation where you would have a very sick pool of individuals very dependent on health insurance. Insurance does not work really well when you are only insuring the people who really need it and allowing them to come in at some later date.

Senator CARPER. One of my guiding principles in life is to find out what works and do more of that. As a previous Governor and Chairman of the National Governors Association (NGA)—and I chaired the National Governors Association Center for Best Practices—I said to my cabinet in Delaware—when trying to wrestle with a particular problem, I would always say, “Some other State—some other Governor has dealt with this successfully. Maybe an insurance commissioner has dealt with this issue—maybe a Lieutenant Governor has dealt with this issue successfully. Let us find out who did it, how they did it, and whether or not the idea is transferable to Delaware.”

In Massachusetts, when they launched the program there under Governor Romney, my recollection was, in terms of addressing lack of coverage, they addressed it. And, the plan, as I recall, really ensured that a lot of people got coverage.

What they did not do well out of the starting gate was addressed costs. You have mentioned this a time or two in your statement. One of the things I recall—lessons learned from Massachusetts—I am going to ask you to share with us what those lessons were—but one of the things, it took a while for the penalty, if you will, for people who did not sign up—like my kids—my sons, who are 26 and 28 years old.

Those who did not sign up, it took some while for the penalties to rise to a level that they actually said, “I might as well go ahead

and get coverage.” And, it helps to provide for a better insurance pool to serve.

The other thing is, you had a lot of people who did not have health care in Massachusetts—and, frankly, in our States today—who have not had health care for years. They are not in good shape. And, once they have health care for the first time—maybe, in their lives—they are using it. And, that has had an impact on utilization and an impact on costs for insurers. And, they are trying to recover those costs. They did not have much experience. They did not know what it would be. It was like playing in the blind, trying to figure out what the rates would be without any kind of real experience.

So, is there anything you can share with us—lessons learned in Massachusetts that might guide us, as we go forward for the country?

Mr. KREIDLER. I think a number of us have looked to Massachusetts and their experience since they had a running start with the Affordable Care Act under Governor Romney. And, one of them, certainly, was having an adequate penalty, so you really incentivize people, so they did not hold out until they needed health care, because that was devastating. I think the other is, you cannot allow—you have to minimize the ability to get into health insurance coverage outside of the open enrollment period. So, you really encourage people—if you get a bad diagnosis, you want to be treated right away. You do not want to have to wait months before you will have the coverage you need. So, that was an important part.

We wound up also finding it interesting—and Massachusetts did too—and that was that there was a prediction that the emergency rooms would be overrun with the expansion, particularly, with Medicaid expansion, in the respective States. We had the same prediction. The actual impact was that it was the opposite. We had a 10-percent reduction in people entering emergency rooms in the State of Washington. And, that was also reflected in Massachusetts.

The reason is, when you go in there with a non-emergent issue, you are told, “You know what, if you go down to the clinic down the street, the doctor in the box, so to speak—get your care there—it is going to cost you a lot less than getting it from us.” It is remarkable how people were sensitive to that price indicator. There were a number of lessons like that that were learned.

Senator CARPER. All right. Lastly, you have mentioned in your testimony the need to promote competition. And, give us one or two just really good ideas of what worked in your State—and you think might work in others.

Mr. KREIDLER. First, you have to stabilize the market. Some things came out of the Affordable Care Act having the essential health care benefits—the out of pocket expense limitations, but, beyond that, you have to try to make sure that you consolidate the risk pool.

Insurers need stability. They are going to gravitate to that. If it looks predictable, they are going to be much more willing to enter a market, and that is where you start to get more competition. Unlike a number of States, we went from 11 insurers to 13 in our individual market in the State of Washington. And, I think that is

a part of it—that we embraced that part of it. Even if it meant taking some pushbacks, such as those canceled policies that we had out there—rather than trying to apply cardiopulmonary resuscitation (CPR) to them to bring them back—we wound up saying, “No, those are out of the market now.” And, it really helped to stabilize the market. I think those are the kind of changes that insurers are looking for, and it gives us the kind of predictability we would like to see.

Senator CARPER. Thank you. Thank you so much.

Chairman JOHNSON. Senator Portman.

Senator PORTMAN. Thank you, Mr. Chairman. And, this has been a very interesting discussion.

Our health care system was not perfect before the Affordable Care Act, but, as indicated by pretty much every speaker today—even you, Mr. Kreidler, and I appreciate you saying this—many of the pledges and promises that were made just have not been kept. And, you can say, “Well, that is because of overpromising, and it still means that this is an improvement.” But, I have to tell you, for a lot of my constituents, it is not an improvement. It has created more problems for them. It is not just higher costs. It is people losing their insurance.

We have not even talked about the CO-OPs, which are part of the Affordable Care Act. And, this Committee has done some good work on that, as well as our Subcommittee—and we have tens of thousands of Ohioans, who have lost their coverage under the co-op, because, pretty much every few weeks, another co-op goes under. And so, this has been tough for people.

I have 30 specific examples here from constituents that I brought with me today out of the hundreds we have gotten, because we have a portal on our website, where people can tell us their experience. I am not going to go through all of them, because we do not have time. But, all I can say is, it is not just this theoretical issue that is a debate about health care policy. It is about people’s lives, their families, and their inability to get insurance that covers them. So, I think you have done a good job, Lieutenant Governor Taylor, today, in talking about the numbers. But, behind those numbers, are people, so here is Chad from Archibald. “The plan we had when Obamacare signed the law—the one we liked was canceled. At the next renewal, company said no longer able to do it due to the law’s passage—did not meet the requirements of the law—promised we could keep our plan if we liked it—promised lower rates. Our premiums have risen 92-percent,” he says, “And, we keep raising deductibles to keep it from going up more.” And, I hear that a lot back home. People say, “Yes, I have health care coverage, but really I do not, because my deductible is \$5,000—\$7,000 now—and that means it is like I do not have coverage.”

One thing that I think that we should point out—and I could not agree more with Senator Carper and others who spoke who said we need to do this on a bipartisan basis. That was not done with Obamacare, obviously, as Senator McCain—who was here at the time—talked about it. I was not here at the time, but I saw it being shoved through. We have to figure out how to deal with this issue of not just the cost, but the quality of the care—and competition is going to help with that too, right?

So, let us talk about competition for a second. You have given some troubling testimony today, Lieutenant Governor Taylor. And, you talked about the fact that you are seeing a big increase next year. I think you said these rates are about a 12-percent or a 13-percent increase next year. Who can afford that? This in an exchange—it is an individual-market exchange. You said that it has gone up 91-percent, since the 2013–14 time period.

Ms. TAYLOR. Yes.

Senator PORTMAN. Wow. What do you see happening in the future? What is it going to be in 2018? And, what is it going to be 5 years from now? What do you think is going to happen if things do not change?

Ms. TAYLOR. Well, it is really hard to predict the future, but, if we look at the past and what has happened over the last several years, my biggest concern for the next couple of years is that we still are not going to have a stabilized market, because, as we continue to lose carriers, writing coverage on the Federal exchange—that obviously creates turmoil within the market that is in that particular district or in that particular region—and that creates a lot of chaos. And, where there is chaos, it is hard to price products.

Where that happens, obviously, it is the consumer in the end who gets harmed, because they are going to pay more or they are going to have—as has been stated by some of my colleagues—they are shrinking provider networks, as we are seeing also in Ohio, where we just do not have the provider networks that consumers in Ohio are used to.

So, my concern is, over the next couple of years—where our early study that we commissioned in 2011 may have predicted that the market would stabilize by now—unfortunately, that has not happened. And, I am not certain that that is going to happen in the next year or two either.

Senator PORTMAN. It has not stabilized. And, what is interesting about your testimony is, it has gotten worse. And, very recently, it has gotten worse.

So, in looking at your testimony here, 17 companies in 2016 were approved to offer health care on the Federal exchanges—only 11 have decided to offer plans in 2017. Is that right?

Ms. TAYLOR. That is correct.

Senator PORTMAN. So, here we had a period where you would have expected some stabilization. Instead, you have just the opposite—and we have 88 counties in Ohio. How many now only have one insurer?

Ms. TAYLOR. Let me find my numbers.

Senator PORTMAN. I was doing the math when you were talking, but I think it is about—

Ms. TAYLOR. I have the math.

Senator PORTMAN [continuing]. About 25 percent of our counties have—

Ms. TAYLOR. Nineteen. Yes.

Senator PORTMAN. Yes. That's about 25 percent, I think, that have only one insurer. I know, again, it is a complicated area. There is lots of debate about what we do, but just a lack of choice and the lack of competition, as it relates to costs—but it also relates to quality of care. Recently, there was a group called the Kai-

ser Family Foundation that put out some estimates on this. And, they are saying that 19 percent of enrollees could have a single insurer by next year—2017. They talk about the increase in costs—substantially double digit increases in costs for people. They just cannot afford it. Eighty-six percent of Obamacare premiums were subsidized by tax dollars. So, people say, “Well, I am not on the exchange”—because most people are not on the exchange. “It does not affect me.” Well, it does affect all of us, because we are all taxpayers.

But, the other thing that is happening in Ohio—and I am told it is happening around the country—is that these insurers, who cannot make a profit under the exchanges, because of the way they were structured, are doing what? They are all staying in business. They are either leaving the exchanges, which, as you see, Aetna just left Ohio, as you reported, a few weeks ago. But, they are also cost shifting, right?

So, if you are a person in an exchange plan, the bad news is your costs are going up dramatically—deductibles, copays, and premiums—everything. If you are being subsidized by that, that helps you, clearly. But then, the taxpayers are obviously paying that. But then, also we have the situation where, if you are in an employer based plan—which is where most of us are—you are seeing an increase in yours as well, because these companies are not going out of business, right?

Do you have any evidence of that in Ohio—that there is cost shifting from the insurance companies, who cannot make it on the exchanges, because they are losing money? And, I assume we have numbers on those.

I know Anthem, for instance, loses money in Ohio and other States they are in. But, these companies are not in trouble, because they are cost shifting on to the private employers. That is a concern that is outside of all we are talking about today, really.

Ms. TAYLOR. Right. Senator Portman, I think it was Aetna, when they made their announcement they were pulling out of many markets across the country, that had announced a \$400 million loss on their exchange—Federal exchange business. And so, I think that just using that number—clearly, there are some insurers that are finding it very difficult. The populations are sicker in the pools than they expected. And, they are having a hard time with the premium increases to keep up with the actual costs.

I think one of the things that has not been said here, if I could—what has not been dealt with is the cost of health care—and premiums are driven by the ultimate cost of health care. And so, where we originally thought that the Affordable Care Act, or Obamacare, was going to place some emphasis on addressing the costs of health care, reinforcing healthy behavior, and getting people healthy and keeping them healthy—instead of only treating them when they are sick—that is not what we are seeing happen in the marketplace.

So, the exchange business—there are certainly some insurance companies that could write it in a profitable way, but I think that more of them than not are finding that it is a loss for them. And so, they have to make a conscious decision. They have to make a business decision. Is it such that they can continue to offer health

insurance on the Federal exchange, even though they are writing at a loss? And then, if they decide to do that, how long can they continue to bear those losses before it, ultimately, is a decision they cannot make any longer?

Senator PORTMAN. Again, my time has expired, but I really appreciate your expertise—and being a CPA and understanding how insurance works—and, as you say, looking at the broader dynamics in health care, which was not done in the Affordable Care Act, unfortunately. That is what we have to do in this place. And, we have to do it on a bipartisan basis—unlike last time—and we have to come up with something that actually makes sense in the real world. So, you have the ability to provide people with affordable, high quality health care.

Thank you.

Chairman JOHNSON. Senator Portman, thank you for raising the cost shifting issue. It has been going on for decades, not only just in terms of Obamacare, but, as providers and governments take over more and more reimbursement, they do not reimburse providers—sometimes to cover the costs—those providers cost shift to the private sector—one of the reasons it put a lot of pressure on premiums to begin with.

The other point I want to make, too, is, you talked about the hundreds of letters you have gotten—we all have—talking about individuals being harmed. They are not pretending. They are really being harmed by Obamacare. I do not know about you, but I hear more and more people on these individual markets just taking the risk. They simply cannot afford the premiums. They look at them—even the high premiums on the insurance they are getting with high deductibles and high out of pockets—and they are going, “What is the point?” So they are taking that risk on, themselves. I am not sure if you are seeing that in Ohio, but I am certainly seeing that in Wisconsin. Senator Lankford.

OPENING STATEMENT OF SENATOR LANKFORD

Senator LANKFORD. So, a year and a half ago, I talked to my daughter’s doctor and asked him point blank, “Why are you no longer practicing medicine after this year? Why are you closing your office?” To which he said, “For 2½ years in a row, we have tried to make this work. And, every single month for the last 2½ years, we have lost money. I cannot keep a practice open and do this. The new compliance costs—the things that are happening—we cannot stay open.”

So, one of the great doctors in Oklahoma, who has years of experience, retired. He is not the only one. There are a lot of others. And, it is not just my family—it is a lot of families.

Lieutenant Governor, I can very much appreciate Ohio experiencing, since 2014, a 91-percent increase in the premiums. I can understand that, because, currently, border to border in Oklahoma—77 counties—we now have one insurance carrier—one in the entire State. Every other carrier has left.

That one has requested a premium increase for next year of 75 percent from this year to next year—1-year increase: 75-percent. If CMS does not approve it—we are a State that CMS does the approval for—they could just withdraw. The hard part about it is—

and it is the dirty secret of the process for right now in the Affordable Care Act—that, certainly, CMS will approve the 75-percent increase, because then we will have no carriers in the entire State—and we will move from one to none.

When they approve the 75-percent increase, it will change it dramatically for people that are at 201 percent above poverty. For everyone 200 percent of poverty and below, the subsidies will kick in. The taxpayers will cover the 75-percent increase, but, for everyone from 201 percent to 400 percent, their subsidies will not be near enough to be able to cover them. And, those at 400 percent and up, they will face the full brunt of the 75-percent increase. And, even more people in my State will say, “I cannot afford—the one policy that is available, I cannot afford at all.” And, they will go pay the tax penalty when they would like to buy insurance. But, literally, insurance now is so expensive in the State. Even those who want to buy it cannot buy it anymore.

This has a very direct effect on what is happening to the families in my State. For those that are on the subsidies, they will not feel the effects—but those only 200 percent of poverty and down. There is, literally, now a new perverse incentive to say, “If you are at 250 percent of poverty, find a way to be able to get to a 199 percent of poverty or you will not be able to get health care.” That is the wrong direction to be able to direct our country. With only one option that is out there in my entire State, we are in a bad place.

Now, our State used to run something called “Insure Oklahoma.” We were told we could not do that anymore. We used to run a plan to be able to take care of those in greatest need. That is being pushed out. There are other solutions that are out there and other ways to be able to take care of this. Supposedly, the co-ops, as Senator Portman mentioned, were supposed to rush into that space and provide the option. Now, of the 23 co-ops that were started—about \$1.7 billion in total taxpayer funding—only 7 of them are left. And, all seven of them are in trouble. No way the taxpayer will recover that money.

So, we have made it incredibly difficult for people to be able to get insurance on the insurance market in my State, because it is now so incredibly expensive they cannot get it on the individual market—they cannot afford it. So, they either have to go into poverty to be able to get health care insurance or be able to find some employer. But, if you are self-employed, you are stuck.

It is a tough cycle that we are already in. And, in some ways, Oklahoma is the “canary in the coal mine.” And, we are raising our hand and saying, “This is really serious for us. This is what everyone said would happen. We are experiencing it now. It is actually happening there.”

So, my question really is for Mr. Wieske as well. You talked a lot about State solutions and things Wisconsin has done in the past. We have done a lot of things in our State in the past—no longer allowed to do. If you were given the ability for your State to be able to say, “Here is some flexibility to be able to take care of people,” is it your assumption that your State would say, “No, only the Federal Government cares about people in my State. We do not care about people in our State?” Or, is it your assumption that your State would step into that gap and say, “There are people

in desperate need in our State. Give us the flexibility and we will be glad to fill that void?"

Mr. WIESKE. I think the leadership that Governor Walker has shown—as well as our State legislature—over the years would show that, yes, we would absolutely want to take care of our State. And, we have actually done that, because we have expanded Medicaid eligibility up to 100 percent of poverty, where the State is, in fact, covering a piece of that. So, for the first time in Wisconsin, everybody in poverty is covered under our Medicaid plan. So, Wisconsin has started down that road. We would love more flexibility to be able to do it fully.

Senator LANKFORD. What would that look like practically? What are the plans and options that you would put into place?

Mr. WIESKE. Well, I think we need to take a look at what the options were, but I think we would, probably, to a large part, go back to a sort of "high-risk pool" that we had in the past. I think that was well functioning and did a good job of taking care of folks who had significant medical conditions in the State. And, it was a good funding procedure. It brought subsidies.

We had a good program under BadgerCare to provide coverage for those folks in need. And, I think, if you look at the rates that I highlighted in my testimony—if you move the rates back down to a more reasonable level—if a 21-year-old does not get a 75-percent increase or more in the first year in Wausau—and a 21-year-old in Milwaukee does not get a 78-percent increase—they are more likely to join the risk pool. So, there would be a number of things that would help lower the rates and bring more competition.

We are facing the same thing that Ohio is. We have 15 carriers and we have expanded service areas. And, where folks are covering has been in turbulence for the last several years. So, our market—despite the fact we have a highly competitive market—we have more insurers in Wisconsin than most States—it is in turbulence. And, more carriers are offering coverage off of the exchange than on. And, that is, in part, a reflection of the fact that it just does not work for them. And, our on-exchange carriers have literally lost—even the well capitalized ones—millions of dollars in value from surplus. So, eventually, they are going to be at even greater risk.

Senator LANKFORD. Well, we have dropped down, as I mentioned, to one carrier. At the same time, several of our rural hospitals have closed in the last several months. Others are on the brink of that. And, it is a very difficult time for them to be able to manage what is happening right now and the requirements that are put on them.

So, as we watch rural hospitals close, physicians retire early, other physicians merge into hospitals, other hospitals merge, and insurance companies around the country merge, we are not watching a healthy future for where we are in health care. We can say we are sustaining where we are now, but we can see quickly where things are going—and it is not a healthy mark in the days ahead.

So, I appreciate all of your testimonies and for being here and being part of this.

Chairman JOHNSON. Thank you, Senator Lankford. Just a quick point: I cannot tell you how many doctors in Wisconsin told me they are retiring early. And, even worse, they are telling their kids,

who have always wanted to follow in the footsteps of their mom and dad, "Do not go into medicine." Some of them have even actually paid them incentives not to do it. So, it is a pretty sad state of affairs. Senator Ernst.

Senator ERNST. Thank you, Mr. Chairman. And, again, thank you to our panelists today and witnesses.

Commissioner Gerhart, thank you for being here, today. It is great to have someone representing Iowa and sharing some of our concerns on the panel today. I enjoyed your testimony—only because it is the same thing that I have heard over and over again, as I am traveling across Iowa.

What I do not enjoy about that is the fact that the stories that are being shared by our wonderful Iowa families are stories of hardship, and what the ACA has done to their families.

We all have very serious concerns about how our families will be able to continue to afford the Affordable Care Act—those insurance policies. And, I hate to say that I agree with you that Iowans and folks across the country have been placed into a situation where they are attempting to decide, "Do I pay for my mortgage, or do I purchase health insurance?" And, I have heard that time and time again. It is either a mortgage payment, because the insurance costs now are so much more than they were previously. Is it a car payment? Is it a truck payment? Is it a tractor payment? I mean, there are so many considerations that families are now making that they did not have to make a number of years ago.

A family of 3 in Kossuth County, Iowa, reached out to my office to share that they are currently paying nearly \$8,000 annually for 2 policies. One with a nearly \$6,000 deductible, and the other with a \$2,500 deductible per person. And, based on initial rate requests, they received notice that one plan is expected to go up 37 percent and the other plan 46 percent, putting them over \$10,000 in premiums for next year. And, one family member already took a second part time job off of the farm that barely covers the \$8,000 premium expense now. And, the family has had very few medical costs so far this year and, rightly, asked me why, as healthy participants, they keep facing these increases.

You also mentioned some pretty shocking statistics. We know that Aetna found that 5 percent of spenders drive 60 percent of costs.

Can you explain a little more in detail what certain Federal policies are driving this?

Mr. GERHART. Sure. Carriers have to have one individual risk pool for the individual market. And, again, if you have a catastrophic claim or a series of them, it drives the whole pool. And so, in Iowa, at least, we have had significant claims of one family driving upwards of 10 percent in one individual pool.

So, we had a functioning "high-risk pool", and what has happened is the industry used to true that "high-risk pool" up to the tune of about \$20 million annually. Now, that chronic spend is put onto the backs of insurance carriers. So, that pool is driving a lot of the rate. And, I heard it in my public hearing on these issues, Senator, where folks were really upset.

To give you an idea, my family of 5—soon to be 6—if I wanted to buy a plan in Des Moines, Iowa, I think the cheapest plan I

would find with deductibles is probably about \$26,000 a year. That is the cheapest Silver plan. So, it is a cost issue. People have to make significant kitchen table decisions.

Senator ERNST. Absolutely. And, we do hear it all of the time as I am out traveling across the State. So, thank you for that.

As I mentioned, Iowa families are paying a lot for these premiums. And, they still have the high deductibles and other out of pocket costs, but one thing I hear commonly from folks that reach out to my office and reach out to me is, they did not realize what their deductible meant when they bought the plan. And, others ask why they are paying all of this money in premiums when they likely will never reach the deductible.

And, I understand that lower premiums on the front end generally will mean higher out of pocket expenses and costs when accessing services, but can we help consumers look beyond the price and focus on the benefits and the network associated with the plans in this high premium environment? Is there a way we can do that?

Mr. GERHART. It is difficult, to be honest. And, we have done a lot of consumer education around the deductible issue, because, I would submit to you, \$13,000, for the average Iowa family, is really not having insurance. They do not have \$13,000 in their checking account to write that check if they actually use it. It is a really difficult issue. We tell folks to shop around. In some counties, there is only one option, so there is really not a lot of choice, to be honest with you. The plans that are out there are more narrow in network. Those might be cheaper. We have some new joint ventures that are kind of like an Accountable Care Organization (ACO).

So, putting some of the risk in the provider community, I think, makes some sense so that the doctors have some skin in the game to keep the patient well. But, again, we have to look at prescription drugs, costs, and transparency. Insurance was fixed through Obamacare, and now a carrier has to pay out 80 percent or more—depending on what group they are in—but we did not look at the actual cost. I think, until we look at the entire system of health care, we are going to be having this dialogue for a long time.

Senator ERNST. Yes. And, I know I have shared this story with you too, about a young beginning farmer that really—his plan was canceled—a \$300 plan, which was perfectly acceptable to him. It was canceled. It did not meet the requirements of the Affordable Care Act. It was replaced with a plan. The cheapest he could find was \$700—so a \$400 difference every month—which he was very angry about, because that was his truck payment there. And, his deductible was \$10,000. And, he said, “I do not have \$10,000. If something should happen, I do not have it.”

So, it is hurting our families. It is hurting those that are just starting out in the workforce, especially if they are self-employed. And, it targets many of our farmers and ranchers across the State. So, it has been very difficult for us. We could go on and on.

I know you mentioned a solution for the “high-risk pool.” You mentioned the particular family that has had about \$12 million of costs, which is a significant concern. Can you explain a little bit more about what that risk pool—your solution to that risk pool would be?

Mr. GERHART. Yes. My idea would be—like Commissioner Kreidler, giving the carriers predictability of pricing is critical. And, if a carrier with no lifetime limits—no annual limits—you get a catastrophic claim like that, Senator, your whole balance sheet could be disrupted, certainly, if you are a small regional carrier. So, our theory is, if those folks went into some other pool—whether State backed or Federal backed—where their coverage would still continue in some fashion—they still pay the premiums—if you told the carriers—you could almost pick a number. Say you have to pay the first million—it does not almost matter what the number is, but you are on the hook for \$500,000 or \$1 million. After that, it goes to this other pool that is more of a societal spend. I think that makes a lot of sense, because, in smaller States, like Iowa, the risk pool is just not that big. So, you get a catastrophic claim like that, in a pool of 21,000, and it is going to really hurt everybody in that pool. In our written testimony, we talk a little bit more about how that would work. I would be happy to explain that further if there is more time.

Senator ERNST. OK. Wonderful. Thank you very much.

Chairman JOHNSON. Thank you, Senator Ernst. Let me give you the opportunity.

I am not quite sure whether every State's "high-risk pool" is funded the same way. I believe Wisconsin's was just basically a surcharge on everybody's insurance, correct?

Mr. WIESKE. It was a surcharge. It was paid by the insurers, and then the providers—medical providers—agreed to a discount, which was a portion of the contribution and then premium—

Chairman JOHNSON. So, rather than have the adverse effects, as Commissioner Gerhart is talking about, you pool everybody. Everybody that are basically allowed to operate insurance in the State are paying premiums into that. And, the system worked great. I mean, it, literally, worked great.

When I was running my business, we would go to renewal. And, there would be somebody, maybe, with a cancer or something like that. They were never dropped from coverage, but they were not offered coverage. They were called "lasered out." But, because we had the "high-risk pool", we would immediately go there, because, if they were denied coverage—immediately qualified. We purchased—and there was a menu of different types of coverages—different deductibles and different out of pockets. We could almost always come up with one that is, basically, identical to our own group plan—pretty comparable prices.

It is a system that worked well. It was complete risk pool sharing—and nobody had to raise their rates astronomically to protect themselves. So, it actually worked.

I do want to talk about it, because it is true. And, when you are facing a total cost—literally, I have talked about somebody—\$1,400 per month. You are getting up into the \$15,000 to \$16,000 per year, plus you have your deductibles of \$6,000 to \$7,000. You are, literally, talking about having to pay \$20,000 or more before you get any insurance. And so, what I am seeing in the State—people are telling me that they are just dropping coverage. People that always had health care coverage—always were responsible to cover—they just simply cannot afford it and they are willing to take the risk,

because they are going, “What is the risk, other than a catastrophic instance?”

I would like all of you to talk about that phenomenon in your own State. We will start with you, Lieutenant Governor.

Ms. TAYLOR. So, in Ohio, the “high-risk pool” that existed just immediately before Obamacare was fully implemented was actually subsidized by the Federal Government. It was set up and essentially run by the Federal Government. And, it was subsidized by the Federal Government. So, it is a little different, it sounds like to me, than, maybe, what was explained in Wisconsin.

Chairman JOHNSON. How did you guys get that done?

Ms. TAYLOR. That was before my time (BMT). And so, it is different. However, we did regulate the insurance side of it, because it was, basically, underwritten by an insurance company in north-east Ohio.

I will tell you, though, it was a unique arrangement, but we also had disputes with HHS. In particular, there were two disputes during the time since I have been in office. One was related to premium levels our actuaries looked at—the cost of the “high-risk pool” and the premium level necessary in order to sustain the “high-risk pool.” And, HHS refused to accept what we believed was actuarially justified. Of course, we then believe that puts the “high-risk pool” at risk. And then, obviously, the consumer, ultimately, is harmed.

I will tell you that the second disagreement that we had with regard to the “high-risk pool” was whether or not certain individuals would be eligible for coverage under the “high-risk pool.” Ultimately, we disagreed. The insurance company ended up having to file a lawsuit against both us, the Department of Insurance, and HHS in order to make a determination about which direction they were supposed to go.

Chairman JOHNSON. So, there are always strings attached to Federal funding?

Ms. TAYLOR. Yes.

Chairman JOHNSON. But, again, I wanted to speak to the phenomena of individuals—people on the individual market with such high premiums and such high deductibles that they are just not taking insurance.

I want to know how big of a problem is that in Ohio, Wisconsin, Iowa, and then Washington.

Ms. TAYLOR. I can tell you, specifically, I talked to an individual—it has been about a year and a half ago—small business owner in central Ohio. And, her comment to me was, “The premiums are what they are.” She said, “But, if I get sick, it is going to cost me \$12,000 out of pocket, in addition to what I have already paid in premiums in order to receive coverage. I do not have \$12,000. I cannot afford to get sick.”

Chairman JOHNSON. By the way, we are also seeing the same thing with people subsidized by Obamacare, because of the high deductibles—still do not access care, because they cannot afford it. I think that point has been made. Deputy Commissioner Wieske.

Mr. WIESKE. First, I would note that the uninsured rate had—the methodology that the U.S. Census Bureau used has changed. So, we may be talking about apples to oranges, as far as the num-

bers go. I think that is a concern of mine, when we look at those numbers, because Wisconsin, traditionally, has had a very low uninsured rate. We landed this time at sixth—and that is where we typically landed: sixth or higher—from an uninsured rate perspective.

Chairman JOHNSON. Just really quickly, I have information that, in 2010, about 94 percent had had insurance.

Mr. WIESKE. Yes.

Chairman JOHNSON. Eighty-nine percent full time and 5 percent part time. In 2004, 94 percent had insurance.

Mr. WIESKE. Yes.

Chairman JOHNSON. Eighty-nine percent—it has not changed.

Mr. WIESKE. It has been very consistent in Wisconsin, and we are fortunate for that, because of our competitive market, I think, which is becoming less competitive.

The individual market has grown because of Obamacare, but I think the scary thing is, the large group market and the small group market have shrunk. We expect the large group market to shrink, because they are moving into unregulated—at least by the State's ERISA plans—which is their prerogative—and the small group market has shrunk by 30,000 folks.

So, if you factor in our changes in Medicaid and the loss of a “high-risk pool”, that is, in fact, probably, not any gain in the individual market, as far as the enrollment goes. It is actually a drop.

Chairman JOHNSON. When you talk ERISA plans, are you talking about employer's self funding—

Mr. WIESKE. Self funding, yes.

Chairman JOHNSON [continuing]. And, starting their own—

Mr. WIESKE. Correct.

Chairman JOHNSON [continuing]. Within their operations—

Mr. WIESKE. Correct.

Chairman JOHNSON [continuing]. Which we are doing—so we have some real innovators in Wisconsin doing that.

Mr. WIESKE. Yes. So, there were about 200,000. We are OK with that, but there are about 200,000 folks, who are in fully insured plans, who moved from that to self funded. And, the question is, why were they in fully insured before and why did they move into self funded? And, Obamacare is the reason they moved.

So, there may be a reason for that. We are supportive of employers providing coverage. So, I do not want to imply that, by any means necessary, but I think it is a concern when you see that sort of sea change shift, and it is caused by a Federal law change. And, I think that is where we are concerned.

And, I think, as far as folks going without coverage, we are seeing this pretty consistently in Wisconsin. We are hearing about it—that people just cannot afford coverage. We are hearing about it from our legislators. We are hearing about it from consumers who call our consumer lines. We do not have any good numbers on that, but we are hearing this as a phenomenon. And, based on what we see, we really have not seen the individual market grow as much as you would expect, given the subsidies—80 percent in subsidies—etc., that would indicate that there has been real movement in getting private coverage.

Chairman JOHNSON. Because having insurance is not the same thing as having access?

Mr. WIESKE. Correct.

Chairman JOHNSON. Bottom line. Senator Carper.

Senator CARPER [presiding]. I think the vote has started. And, we are going to come and go here for a while and try to conclude around noon or so.

Again, thank you for joining us.

I have a question for the record (QFR) that I am going to submit for you, Governor Taylor, and if you could respond to that, that would be great.

I am going to ask Commissioner Kreidler to just think out loud. We have heard a fair amount about risk pools and other steps that States have taken or would like to take. Give us a short list of things that you would recommend that, when the elections are over or in a new year—new Congress and new President—what are some things you would recommend that we do on this end? Meanwhile, what are some things that the States should be doing—could be doing and should be doing on your end?

Mr. KREIDLER. Senator Carper, I appreciate this question, because I think what I have noticed—even in the discussion that we have been holding this morning—is that there is more of a focus right now on what we can wind up doing to make the system work better. And, one of them, certainly, is the concept here of having some form of a reinsurance or risk pool that would help to mitigate the risk and exposure that insurance companies would have, so they do not wind up with the particularly very sick people or many of their people are much sicker—that there is more of an adjustment here between the insurers, so they can predict their exposure and have the benefits of a much larger risk pool—rather than just the people that have bought their particular policy.

I think that is a step in the right direction. That is starting to look at what we can do better than what we have right now.

Senator CARPER. Let me look at our other panelists. Would you just nod your head yes or no if you think that makes any sense. Thank you. Three heads nodded yes. One vigorously.

Mr. KREIDLER. Senator, you also made mention about Massachusetts. I think one of the areas that would help a lot—and it really goes to the questions that have been raised about affordability that we have heard and, I think, where everybody is very sensitive—and, particularly, those of us who are regulators, because we are on the front lines. When those people have problems, they are calling us and registering their sentiment on the issue.

And, that is something that Massachusetts has, which is the ability to move into what is referred to as “active purchasing” and “standardized plans”—“value plans,” as they are sometimes called.

Senator CARPER. What does that mean? I think I know, but what does that mean?

Mr. KREIDLER. It is interesting. We were just at our national meeting, and we had a professor from Harvard, who is on the exchange board in Massachusetts. And, it really is just trying to make sure that those medical services that are really high value—meaning that you do not want people to delay, whether it is hypertension or diabetes, whatever it might be—you want to make sure

they are getting those services. Bring down the out of pocket expenses, the copays, and the deductibles. Make it easier to get those particular services, because they have such a profound impact on the level of health of that individual.

I think the States are in a unique position to be able to experiment along these lines. Massachusetts—California is moving in that direction. I am hoping that maybe I can take that issue to my State legislature this January so that we have that ability to do it. We did it—both California and Massachusetts have their own State exchanges. We do too. I would like to have them have the kind of power, so we can get in there and really explore what we can do in improving the value of those plans by making sure those really important services are not impeded due to the out of pocket costs.

Senator CARPER. All right. Give me one more good idea for us—for the Federal Government, please.

Mr. KREIDLER. I would have to tell you, from a Federal perspective, I would obviously strongly encourage—because of the impact it had as the principal medical driver on the rates that I am looking at, right now, in the State of Washington—and that is pharmaceutical. The more that can be done to address that very tough, ticklish issue—and I understand that profoundly. At the same time, we are really out of line with other countries. We really need to bring down those costs.

Stabilizing the market is very dependent on bending that cost curve down, so it does not rise as fast as it historically has. If we do not do that—getting everybody insured—the Affordable Care Act—it is not going to matter. We will be back to what we had before the Affordable Care Act—a whole system that is failing. We need to bring down the cost of health care.

Senator CARPER. All right. Thank you.

I want to go back to something that my friend John McCain said during his visit to our hearing today. And, Senator McCain mentioned that we passed the Affordable Care Act on a party line vote. And, I think what he did not say, though, is that we had the longest markup in history on the Finance Committee, prior to that. We voted on literally dozens—I think, scores of amendments—Republican and Democrat. He did not mention that Senators Max Baucus and Chuck Grassley—two very close friends, as it turns out—spent over a half year together with four of their colleagues—two Democrats and two Republicans—to try to find a bipartisan compromise. And, three of those people—Republicans—had an inordinate amount of pressure applied to them not to find a compromise. And, they, ultimately, felt compelled not to help find a compromise.

I was there. And, there are three very fine Republicans—and three really good Democrats as well—and there is a lot of pressure on my Republican colleagues just not to find the middle.

But, there is a community called the Health, Education, Labor and Pension Committee (HELP). They spent a full month deliberating the law on a bipartisan basis. The House held 79 bipartisan hearings and markups on the health reform bill over the period of an entire year. The Senate held dozens of public meetings and hearings in both the Finance and the HELP Committee—and accepted hundreds of Republican amendments. The Health, Education Labor, and Pension Committee held 14 bipartisan

roundtables, 13 bipartisan hearings, and 20 bipartisan walk-throughs on health care reform.

The HELP Committee considered nearly 300 amendments and accepted more than 160 amendments—many of them offered by our Republican colleagues. The Finance Committee held, meanwhile, 17 roundtables, summits, and hearings on health care reform. Our Committee also held 13 member briefings and walk-throughs as well as 38 meetings and negotiations, for a total of 53 meetings on health reform. And, our Committee—the Finance Committee also held a 7-day markup of the bill—I think that is the longest Finance Committee markup in 22 years—resulting in a bipartisan 14 to 9 vote to approve the bill. And, finally, the Finance Committee markup resulted in 41 amendments to revise the bill, including 18 unanimous consent (UC)—or without objection.

And, as to the reliability of the insurance plans, my friend, Senator McCain, did not mention that consumers regularly lost their insurance rights when they did get sick and when they needed it the most. And, in those days, premiums did go up—and, in some cases, by as much as 10 percent or 20 percent. I just want to put those things on the record.

I want to go back to the issue of competition for our witnesses, if I could. There was one of my early mentors when I was State Treasurer. He was a very successful businessman—older man. In Delaware, he was also the Chairman of the State Pension Plan. His name was Ernie Dannemann—and he ran a very successful fiber or fabrics business in our State—in fact, in several States. He used to have the saying—it is not original, but he used to say, “Competition: first it makes you sick, then it makes you better.” And, I think what we need here is competition—not just on the insurer side, but on the provider side. And, we have heard some ideas as to how to do that.

And, I think the second thing that we need is to make sure we have a purchasing pool that insurance companies can actually afford to insure and to make sure it includes a mix of people—healthy and unhealthy people.

We talked a bit about this. You all offered different ideas or examples, but just let us go down the row, if you could. Governor Taylor, just on the competition—maybe, one particularly good idea that you think would enhance competition—either for the insurers or for the providers, please.

Be very brief, if you could.

Ms. TAYLOR. From the insurers’ perspective, I would say that it is less regulation—open market and consumer choice—and let insurers write the type of coverage that individual consumers want to purchase.

Senator CARPER. OK. Thank you.

Mr. WIESKE. It is the same thing in Wisconsin. We are seeing relatively homogenous plan designs because of Federal rules. And, I think that is a bit of a problem. Similar structures—similar provider network issues—that they are doing very narrow networks—and they are doing that to deal with the risk pool. So, I think—and then, they are constantly changing their service areas to reflect that. So, I think finding a way to get better competition and less regulation, I think, would free up and bring more carriers

into the market. That is what we have seen in every other line in Wisconsin.

Senator CARPER. All right. Thank you. Mr. Gerhart.

Mr. GERHART. I will give you two thoughts: One, let the States have more flexibility when we are looking at 1332 waivers and things of that nature when we work with CMS. Another is the Accountable Care Organizations and the alignment of the providers—and having skin in the game to keep the patient well and healthy. I think that is something we need to focus on.

Senator CARPER. In my State we are seeing the formation of a lot of Accountable Care Organizations. And, in your States, are they being formed, as well?

Mr. GERHART. We have quite a few in Iowa, yes.

Mr. WIESKE. We are seeing a different model in Wisconsin, but we are seeing increasing partnership with the medical providers.

Senator CARPER. All right. Thank you.

Ms. TAYLOR. Some.

Senator CARPER. Some. OK. Thank you.

All right. Commissioner Kreidler.

Mr. KREIDLER. I think what has been talked about here is allowing insurance companies to be able to innovate and offer changes without being unduly impeded. At the same time, you need to have the standardization so they maintain respective standards. You do not want an insurance company gaming the system so they get the healthy people at the expense of the less well. That is very harmful to the market and, certainly, to the individual group market that we have right now. So, it is really starting to have some standardization here—on the standards—but at the same time, you have to allow them to innovate.

One of them is going to these narrow networks, which we have an obligation to make sure there is an adequate network there, to provide the services and the promises that are made with that particular policy. But, allowing them to go there—and go to the highly managed plans that we are seeing as a trend right now in the marketplace. It is an innovation that can help hold down costs, but it needs to make sure they do not game the system inappropriately at the expense of the whole system.

Senator CARPER. All right. I may have said this earlier in the hearing, but I want to just say it again. We compete with a lot of different nations on earth. There are competitors. One of our strongest allies, but also a very strong economic competitor, is Japan. And, for years, I remember learning this when I was—I think it was my second year on the Finance Committee—2009 or 2010—and one thing we learned in the hearing was, in competing with the Japanese, they were spending 8 percent of gross domestic product (GDP) for health care costs—8 percent. We were spending 18 percent. The Japanese were getting better results. People lived longer and they had lower rates of infant mortality than we did. So, they are spending less money, but getting better results.

In addition, at that point in time, we had 40 million people going to bed at night with no health care coverage—nothing. If you are lucky, you could go to a hospital—maybe, emergency room—and try to get something, but, for many of them, there was nothing.

And, we have had some heart wrenching stories shared with us about individuals who are having a hard time affording the premiums and making sure they can have coverage for themselves and their families. There were 40 million people—not just ones or twos—40 million people that were in a situation like that. And, we cannot forget them. We cannot forget them. I am not going to, and I do not think you want us to do that.

I am not smart enough. My colleagues and I, probably, here—even if we all tried to figure this out together—are not smart enough to figure out how to take a very good idea and make it an even better—not just idea, but program—and one that entails the partnership with—not just the Federal Government, not just the States, and not just the Governors, Lieutenant Governors, Insurance Commissioners, the providers, and the insurers. This is what we call an opportunity for an “all hands on deck” moment. That is what we used to say in the Navy.

And, that moment is going to come, I think, sometime in January. And, when the sound for General Quarters goes out on the Ship of State, my hope is that a lot of folks, including people in this room—people that I serve with and people who will be new in the Senate—new in, maybe, the White House—that they will answer that call as well. And, we will do what we do best as a country when we prevail—and that is to work together. We have done it. We need to do it again. We did it to clean up Medicare Advantage. We did it to clean up the Medicare Prescription Drug Program, Part D. We need to do it in this case as well.

Thank you all so much. Thank you, Mr. Chairman.

Chairman JOHNSON [presiding]. Thank you, Senator Carper. It looks like you went over your time.

Senator CARPER. Sorry.

Chairman JOHNSON. I appreciate you holding down the fort here.

Kind of along similar lines of people taking a look at these enormous premium increases—their out of pocket deductibles and just dropping coverage—I also want to talk about people gaming the system, because we have certainly heard reports of this where, because, under law, you can sign up for—you can go through the open enrollment period and sign up for the health care, never pay a premium, have coverage for 3 months, which the Federal Government, if they are paying the premiums for you—providing the subsidies—and then quit. Never pay a premium, have insurance for, basically, 3 months out of 12 months. Is that something you are seeing in your States? I will start with you, again, please give kind of quick answers. I have a number of questions.

Ms. TAYLOR. I do not have a specific example of that, but it is certainly a concern. And, I can tell you, in speaking with providers in a hospital organization yesterday—one of which was a rural hospital who had recently filed bankruptcy—those kinds of issues are significant—especially in our rural communities, where they have less ability to absorb those types of losses.

Chairman JOHNSON. Commissioner Wieske, do you see that in Wisconsin?

Mr. WIESKE. We do. We have heard from the insurers consistently, yes.

Chairman JOHNSON. Is that a growing problem?

Mr. WIESKE. I think it is. Yes.

Chairman JOHNSON. Commissioner Gerhart.

Mr. GERHART. We have heard that and also with the special enrollment period (SEP) as well—lack of oversight on the special enrollment period. The claim I discussed earlier was a special enrollment. So, we are seeing the morbidity of the special enrollment crowd—about 100 percent to 200 percent more, on average.

Chairman JOHNSON. Again, people are smart. If they see a system that can be gamed—the more they see it, the more they will do it, correct? Congressman Kreidler.

Mr. KREIDLER. I am not seeing it in the State of Washington—the kind of people who will come in for a few months and then get out. But, special enrollment has been an issue. And, purely from the standpoint of being a regulator, you look at it and you say that if you want to stabilize your market, you cannot allow people to have multiple opportunities to go into the market. And, that is something that, I think, as an association of—across the country, we have spoken out and said that we do not like the idea of having the extent of special enrollments that we see because it is harmful to the quality of the overall market.

Chairman JOHNSON. You mentioned the term “stabilized markets.” One of the signs of a market that is stabilizing would be if the price increases were actually declining over the years. And, certainly, what happened in Wisconsin is an enormous price increase that first year at the individual market. But, nationally—and I am going to quote an individual. Charles Gaba has done a study. And, you said that, between 2015 and 2016, on the individual market, there were rate increases somewhere between 12 percent to 13 percent. Between 2016 and 2017, they are looking at somewhere between 25 percent and 26 percent. That is going in the wrong direction. That is not a sign of a stabilizing market, correct?

Does Anybody want to talk about that or dispute those figures?

Again, part of the problem we have discussing this is that it is so hard to get good, solid metrics, because things are all over the map.

Commissioner Gerhart, it looked like you wanted to speak.

Mr. GERHART. Well, in 2013, during my confirmation hearing, I thought that, by this point, we would have a stable market. And, it is not stabilized. We are looking at about 100-percent rate increases and our individual purchasing insurance has actually gone down. We had 189,500 folks that purchased individual coverage pre-ACA and now it is about 184,500. So, we have actually seen fewer people buying their own coverage. Even though our uninsured rate has gone down, because of the expansion of Medicaid.

Chairman JOHNSON. Again, the fewer people who participate in these “high-risk pools”—they are going to self-select and they are going to be the sicker—and, again, it just makes it a less stable system.

Commissioner Wieske, did you—

Mr. WIESKE. That is correct. And, this is typical, when you have seen certain kinds of reforms, that when you hit this year—the third year of implementation—and you are moving into the fourth year—if you look back at College Health IPAs (CHIPAs) that were implemented in a number of States—you look back at a number of

other reforms that went in States—it is, typically, this third to fourth year where you start to see the spike and you start to see what is called the “death spiral” in some of these markets—where the rates are increasing and your risk pool is getting worse and worse.

Chairman JOHNSON. One thing about Obamacare—it is really affecting the individual market—less so on the group market. I do want you to speak a little bit about that. From my standpoint, fortunately, the group market has been able to operate and has not seen—although, as Senator Portman talked about, you are going to—and you probably already have seen the cost shifting of insurers from the individual market, because they cannot recover and shift that over to the group markets.

But, can you just sort of speak to the dynamic curve there? And, Deputy Commissioner Wieske, you talked about people moving plans out of the group market into ERISA plans—completely self-insuring and completely leaving the market. So, I would like all of you to kind of just talk about that dynamic between the individual market and the group markets, and what is expected in 2017 and beyond.

We will start with you, Lieutenant Governor.

Ms. TAYLOR. So, I do not have numbers to speak, specifically, as far as enrollment and the exact shift of individuals from the individual market to—or group to individual market or vice versa. I do think that it is human nature to move to the path of least resistance, which in many cases is: “What is going to cost me the least amount of money?”

And, we have not seen quite the trend that you are commenting on, with regard to employers going to self-insured plans. However, I do expect that to change. I do think that we will see more of that going into the future—especially, as where—even if we stated that a 12-percent or a 13-percent premium increase—which is significant—our largest increase was in the first year. We had a 51-percent, on average, increase in the first year. Even if we thought that we could get to a point where we are stabilizing premiums, we are still not stabilizing the market with the carriers where you have 19 counties with one carrier. You are still not stabilizing your market.

Again, I do not feel like we have the stability in the market—and your point is, are you cost shifting? I guess, for all intents and purposes, that is what a pool does. A pool does cost shift from one individual to another—for all intents and purposes—for insurance purposes. I do not think that we could give you any numbers though to speak, specifically, to our—how is the individual market shifting to the group or vice versa.

Chairman JOHNSON. It was pretty obvious, politically, that a number of the more harmful provisions of Obamacare were implemented in delayed fashion.

Are there additional provisions about ready to kick in that will affect that group market?

Mr. WIESKE. I think, for Wisconsin, the end of the transition policies—so the president’s promise that if you have a plan you can keep it—and then he sort of at the end—just before 2014, he allowed some transition policies. So, in Wisconsin, we allowed that.

So, in the small group market, there are roughly twice as many individuals in the small group market in transition policies and in grandfathered policies that are not Obamacare compliant than there are in Obamacare “single-risk pools.” So, when we get to the end of 2017, all of those plans—unless they do another extension—will go the way of the dodo. And so, that will create a big sea change in the small group market for us.

Chairman JOHNSON. You will see a cumulative price increase, really, what we have seen since 2013, correct?

Mr. WIESKE. Right.

Chairman JOHNSON. All in one year.

Mr. WIESKE. Correct. So, any of those consumers that have not participated either in the end—we have about 46,000 folks in the individual market who are in that, as well—they will see whatever the rates are in their particular counties, at that time.

Chairman JOHNSON. So, if you take a look at what I said, based on the numbers from the Manhattan Institute, where, in the lowest demographic group, since the inception of Obamacare, premiums have increased at 1.8 times—the highest more than 3 times. That is the kind of cumulative effect you are going to see in the small group market. All of a sudden—bam, like that—in 2018, just hit them like a ton of bricks.

Mr. WIESKE. Potentially, for those in the transition market, yes, they are going to have very significant increases. And, the same thing in the individual market—we expect they will see significant increases next year.

Chairman JOHNSON. That is something people really need to understand. Senator Portman.

Senator PORTMAN. Thank you, Chairman.

I have a question for the group. And, I do not want to hold you guys much longer, because you have been really patient with us. I appreciate all of the input that we have gotten—and we have some really smart people on the panel here, who are going to hopefully help us unravel this at some point and come up with a better system.

But, some of you may have seen yesterday I joined some of my colleagues to introduce what is called “The State Flexibility to Provide Affordable Health Options Act.” And, it basically says that, if you are a family in an exchange and you are in a situation—as is the case of 25 percent of our counties in Ohio or all of counties in Oklahoma, apparently, where you do not have choices, you can go outside of the exchange—use the subsidy to go outside of the exchange to buy insurance. And, it is, to me, not the ultimate solution here, because I do think the whole system needs to be reformed.

But, it is almost surely the stopgap measure that is needed right now to give some of these folks I represent—and from these other States that are even seeing less competition—a little bit of choice—and, again, cost and quality being what comes with more choice.

What do you think about that? I know there is a potential problem with the tax credit—and we need to work on that, but what do you think about that, as a concept, to say, “OK. Let us let people at least be able to go outside the network here to be able to get insurance when their choices are so constrained?”

Ms. TAYLOR. Senator Portman, thank you for the question.

The more choice we can give consumers, the better. The more that we can eliminate overly burdensome regulations to allow the free market to work, so that consumers can choose the type of plans they want to purchase for the prices they can afford to pay, I think, the better off we are. So, I certainly would support an option to give consumers more choice to purchase health insurance.

Senator PORTMAN. Thank you.

Mr. WIESKE. I would note that Governor Walker of Wisconsin sent a letter asking for this in 2013 as well, broadly—and we are very supportive. It does not necessarily make any sense why a consumer should have to send all of their private information and run everything through a Federal exchange in order to be able to get a subsidy. If it is an insurance subsidy, then that might be something that we can look at—look at broadly—and there is some sense—we do not do this for anything else. So, I think, conceptually, it makes a lot of sense.

Mr. GERHART. And, I have not read it, myself. In concept, it is something we would support. It makes a lot of sense, absolutely.

Senator PORTMAN. Mr. Kreidler.

Mr. KREIDLER. My principal concern would be one of making sure the market is not somehow compromised by allowing people out—and what that would do to the integrity of the pool, itself, by doing that. The idea is to get as many people covered—whether they are in a rural area, which is not going to be well served by—they were not well served before the Affordable Care Act. It is an ongoing problem and challenge in rural communities. We want to make sure they are not made second class citizens and it comes at their expense, from the standpoint of having the kind of choices in a free market that they have. That is a task for all of us—regulators and, certainly, for Congress.

Senator PORTMAN. Yes. Clearly, that is exactly the objective here—to avoid that—that is currently happening. I do not know how—Washington is looking at it—exchanges going forward, but, certainly, in a place like Ohio, we are just seeing fewer and fewer choices. And, therefore, that second-class citizen you were talking about—that is, unfortunately, happening within the exchanges.

I will say there are some counties where there are not necessarily insurance companies willing to write at all. We may not have one in Ohio yet, but I am told, from talking to Lieutenant Governor Taylor, we may have that situation in our State, too. So, it is getting dire and we have to figure out a way. This is one, I think, that would provide people the flexibility they need to be able to get the care they and their family need.

Did you want to comment, Lieutenant Governor?

Ms. TAYLOR. No.

Senator PORTMAN. Thank you very much, Mr. Chairman, for allowing me to ask another round of questions.

Again, I appreciate all of the information you guys have provided today. And, I hope you will stay in touch.

Chairman JOHNSON. Senator Peters.

OPENING STATEMENT OF SENATOR PETERS

Senator PETERS. Thank you, Mr. Chairman. And, thank you to each of the witnesses for being here and providing some good testimonies as to what is happening in your States. And, I certainly appreciate the comments of my colleagues here, particularly, Senator Portman. I appreciated your comments talking about how we need to be bipartisan. We have to figure out how to deal with some of these very complex issues and do it in a collaborative way. So, I hope that we are now at the point where we can get away from this partisan divide that has prevented us from dealing with the health care system in this country—where folks think we just repeal—or we are well beyond that debate now. The Affordable Care Act is not going to be repealed, but that does not mean it is perfect—although there is also a lot to celebrate in it as well.

So, we should be in a position to celebrate what is good and fix what is not so good, and take it in a practical commonsense kind of way—roll up our sleeves to do that. And, I think it is also important, as we are having that debate, to remember that the health care system was not all that great before the Affordable Care Act was passed. The reason it came out is because of significant problems that existed, in terms of access and in terms of costs.

I think, in my State of Michigan, prior to the Affordable Care Act passing, statistics I saw showed it was up something like—costs had been growing at 15 times faster than wages. That is not a sustainable course. So, the health care system was not on a sustainable course prior to the Affordable Care Act.

At the same time, you had large numbers of people who simply did not have health insurance. In this great country of ours, we had folks who knew that if they got sick, that might mean personal bankruptcy for them and ruining their family. In fact, I think that the number one cause of bankruptcy—personal bankruptcy—was that someone got sick.

How could we accept the kind of system that existed before the Affordable Care Act where now anybody—even if they have a pre-existing condition—can get health care? To me, that is where the American people are. It is certainly a very popular option—probably, the most popular option as they know, that, if they leave a job and they lose health insurance and they have a preexisting condition, they can still get health care coverage. They are not in a system where they are out of luck. And, it frees up people from an entrepreneur's perspective too—that you are not locked into a particular insurance plan. You can get insurance and you can go off and start your own business and know—even if you have a pre-existing condition—your family is still protected. Your children are protected now, up to age 26.

So, there is a lot. And, if I look at Michigan—the numbers—I think if you look between Medicaid expansion, the marketplace, and the Children's Health Insurance Program (CHIP), it is somewhere around 700,000 people, after the ACA, that now have health insurance. They did not have it before.

So, I think that is significant. And, we should celebrate the fact that we have 700,000 people that now know they have some coverage and protection should they get sick.

But having said that, nothing is perfect. I have never seen a perfect bill in my years as a State legislator and now in Congress. I have never seen a perfect bill. I do not think one exists and never will exist, so you have to go back and refine it and try to find those changes.

So, along those lines, certainly, a lot has been said about competition, which I am very troubled by as well—the lack of competition and how that does not bring prices down.

So, first, for Lieutenant Governor Taylor, you have been particularly outspoken about your concerns about the reduction of competition. And, I think you said, in your testimony, too, that we need to make sure that it continues to be robust.

Under your role as an insurance commissioner, do you have the authority to hold public hearings?

Ms. TAYLOR. Yes, in some cases I do, Senator Peters.

Senator PETERS. So, were you asked to hold any public hearings about the merger between Aetna and Humana?

Ms. TAYLOR. Yes, we were, Senator Peters.

Senator PETERS. Did you hold any of those public hearings?

Ms. TAYLOR. I did not.

Senator PETERS. So, here we have two major insurance companies—and I think you talked about how some places in Ohio have just one insurance company—and now you have two major providers in your State combining, which means less competition. You have talked a great deal about how we have to keep robust competition—and it was my understanding that a number of groups in Ohio did ask you to hold public hearings, because there were concerns that this merger was going to reduce competition, it was going to raise costs, it was going to decrease network adequacy, and it was going to hinder success to the individual market in Ohio.

So, why did you choose not to hold those hearings on the merger?

Ms. TAYLOR. Thank you, Senator Peters. I was referring to my health policy expert. The law, in this case, would not have permitted us to hold a public hearing, because they had met the requirements, under the law, to proceed. There is no specific statute that would have said that we could have or should have held public hearings in this particular situation.

Senator PETERS. So, are you working to change that law in Ohio?

Ms. TAYLOR. No, I am not.

Senator PETERS. Do you think it would be good to have public hearings before a major merger of the magnitude that we are seeing in Ohio, which will limit competition?

Ms. TAYLOR. Obviously, as you well know, each State deals with these types of acquisitions and mergers differently—but they also impact States in a different way. So, where you may have a merger of two very large insurance companies—obviously, being reviewed by the Department of Justice (DOJ), where a determination will be made on its face in total—whether or not there are competitive issues, States deal with this individually. And, individual States may have a different impact on overall competition.

So, where Ohio may be less impacted by that particular merger—from a competitive perspective—you might speak to another commissioner of another State where they would express more concern,

because of the nature of the market that they hold within that State, the type of business that they write, and where and how it might impact competition.

Senator PETERS. So, it sounds like it is a good reason why you should have public hearings in your State, because every State is different. You would certainly want to understand how mergers would impact your State. And, certainly, I would think the people of Ohio would be interested to have that kind of transparency.

And, really, when we are talking about consolidation and what is happening, I am particularly concerned—and I am sure my colleagues have received all sorts of correspondence on what is happening with drug manufacturers—the recent EpiPen situation, where you have a drug that really has not changed much in years, as far as its composition, and, yet, we have seen a 400-percent cost increase by the drug company.

Now, we understand a drug company's need to charge a fair price to have research and development (R&D) and to develop products. And, we all agree that there has to be some return to them. But, when you have a drug that has been out in the marketplace and has not changed, and you see a 400-percent increase that is then passed on either to the individuals who buy it or to the insurance companies that have to cover it—I just had a group of dermatologists in my office earlier this week. And, they are saying that they are seeing 400- 500-, and 600-percent increases in basic creams—things that may have cost—what they were saying was, \$4 or \$5 in the past—are now several hundred dollars for a tube of cream for dermatologists. And, these drug companies are increasing these prices.

So, maybe, I will open it to the panelists and maybe Mr. Kreidler will mention—what should we be doing? And then, the others—what should we be doing to reign in these outrageous price increases from drug companies when there is not even a change in their product—it is at the end of their life cycle—and they are just profiting? The only one that seems to be rewarded are the Chief Executive Officers (CEOs) of these companies. They are getting huge bonuses.

Chairman JOHNSON. We will take that as a question for the record. We are over in time. And, you can submit your responses to Senator Peters for the record.

Senator Portman, you had a quick comment.

Senator CARPER. Mr. Chairman, I would ask for unanimous consent that the panel be given, like, 2 minutes to respond, please.

Chairman JOHNSON. Two minutes maximum.

Senator CARPER. Thank you. Thank you a lot.

Senator PETERS. Two minutes to respond to a major reason why health care costs are going up in this country? That is worth 2 minutes.

Chairman JOHNSON. You could have started your questioning with that. But, anyway, 2 minutes. And then, if you have a further response, you can—

Senator PORTMAN. Mr. Chairman.

Chairman JOHNSON. Senator Portman.

Senator PORTMAN. All of us have appointments. I have constituents waiting for me. And, I appreciate the fact that you want to

have more time than you are allotted. The rest of us have been here all morning, listening to this testimony. I also appreciate the fact you want to get an answer to your question, but you could have asked that question, rather than asking a question that is totally unrelated to this hearing to our Lieutenant Governor—who did a terrific job answering you, by the way, by saying you are wrong. She did not even have the ability under the law to do what you claim she should have done. So, I just want to state that for the record as well. I am happy to stay and keep the constituents waiting, but I hope we can keep to our time. And, I hope Members would show up to these hearings to be able to listen to the testimony and hear from these experts, rather than taking our time here at the end.

Senator PETERS. Well, if I may say, I was here, and you will note I was here and heard the testimony from these folks. And, I did leave to vote. So, I am sorry that I went to vote, but it is one of our requirements, Senator Portman.

Chairman JOHNSON. I understand that.

I will give you 2 minutes, but let us go because I also have another hearing to go to.

So, does anybody want to respond? Start the clock.

Ms. TAYLOR. So, at the Department of Insurance, we regulate the business of insurance. We do not regulate health care, nor do we have any authority over the regulation of health care costs.

Chairman JOHNSON. OK. Does anybody else want to comment on that?

Mr. WIESKE. It is the same in our State.

Mr. GERHART. It is the same in our State. But, I would agree. Prescription drugs—in particular, specialty drugs—are a major issue.

Mr. KREIDLER. I would absolutely agree. And, I think it is important to keep in mind that, before the Affordable Care Act, we were seeing actual rate increases that were going up faster than what we are seeing right now. So, this is not a new feature, and I think it has been well stated by all of the Committee Members, Mr. Chairman, that we really need to start to focus on how we can make this work better.

Chairman JOHNSON. I would suggest the Food and Drug Administration (FDA) reform. It used to take about 10 years from discovery to approval of a drug. Now, it takes about 14 years. It used to cost about a billion dollars, now it is \$2.5 billion. There would be a good place to start—again, governmental reform at the FDA.

Senator Carper, do you have additional questions before I close it out?

Senator CARPER. Just a pretty easy one—maybe, a yes or no.

We talked a bit today about the value of having States increase their coverage under Medicaid and the positive effect you can have, in terms of making the marketplaces work better. And, as an Ohio State alumni—somebody who cares a lot about Ohio—I follow what goes on there—followed my friend Kasich as well from afar. But, your testimony—and I applaud him for having made the change in Ohio that a lot of other States have made.

But, your testimony does not acknowledge the important role that the Affordable Care Act played in allowing States to expand

Medicaid. And, I would just ask: Is this something—do you support Medicaid expansion in your home State of Ohio?

Ms. TAYLOR. So, to address the reason—

Senator CARPER. You do not have to go into any depth. Is that something you support? I know the Governor does.

Ms. TAYLOR. There is no statement here, because I do not regulate Medicaid. It is a separate agency. And, I support the Governor in the decision that he made.

Senator CARPER. So, you think he has done the right thing?

Ms. TAYLOR. I support the Governor in the decision he made.

Senator CARPER. All right. Thank you.

Chairman JOHNSON. Thank you, Senator Carper.

Again, I want to thank all of the witnesses. In the spirit of bipartisanship, here would be my suggestion for a little fix: Eliminate the individual mandate and return a little freedom to Americans. Let the States define what insurance is—let the States regulate. That is the vision of our founding fathers—government is supposed to govern. That would return choice to the American public. And, I am happy to repeal the Cadillac tax.

So, there would be my little olive branch. You want to do some bipartisan reform to fix this, you eliminate the individual mandate, you put the States back in charge of defining and regulating insurance products, and you eliminate the Cadillac tax. That would be a good place to start.

Again, thank you all for your thoughtful testimonies and for traveling here. I would ask unanimous consent to enter a statement by Christina Corieri¹, a senior policy advisor to Arizona Governor Doug Ducey, for the record, without objection.

Senator CARPER. Yes.

Chairman JOHNSON. With that, the hearing record will remain open for 15 days, until September 30, 5 p.m., for the submission of statements and questions for the record.

This hearing is adjourned.

[Whereupon, at 12:24 p.m., the Committee was adjourned.]

¹ The statement of Christina Corieri appears in the Appendix on page 99.

A P P E N D I X

Opening Statement of Chairman Ron Johnson “The State of Health Insurance Markets” September 15, 2016

Good morning and welcome.

Today’s hearing highlights an issue that’s incredibly important to all of our constituents. I spent the summer traveling across Wisconsin speaking directly with Wisconsinites about issues that are important to them. One common concern my constituents raised was rising health care costs. That is because the Patient Protection and Affordable Care Act did not live up to its name or fulfill the promises made about it.

President Obama repeatedly told Americans that “If you like your health care plan, you’ll be able to keep your health care plan, period,” and “If you like your doctor, you will be able to keep your doctor, period.” He also promised that on average, a family would pay \$2,500 less per year under his reforms. Contrary to those repeated promises, millions of Americans lost insurance they liked and could afford. As networks have narrowed, Americans have also lost access to doctors they knew and trusted. And premiums have not been reduced, they have skyrocketed.

As states continue to finalize premium rates for 2017, consumers face a striking reality: Health care premiums are on the rise and marketplaces established under the Patient Protection and Affordable Care Act, or Obamacare, are spiraling out of control. Americans across the country are worried about how they will be able to afford basic health care, and health insurance providers are concerned about whether they will be able to remain in the highly unstable Obamacare marketplaces. Today’s hearing will examine the current state of health insurance markets by listening directly to state insurance commissioners who operate in some of these marketplaces every day.

Over the past few years, Wisconsinites have faced significant premium increases. Based on information from the Manhattan Institute, premiums have increased by a factor of 1.8 to 3.1 times, depending on demographics. For example, a 40-year old woman paying \$193 prior to Obamacare now faces a monthly premium of \$349, an 81 percent increase. A 27-year-old man paying \$92 prior to Obamacare is now looking at \$287, a 212 percent increase.

For 2017, health insurers requested an average 16% increase in premiums for individual plans in Wisconsin. Nationally, insurers are requesting premium increases for 2017, with one study estimating an increase of 24.3 percent for plans in the Obamacare individual market. That study projects a national premium increase of nearly 26 percent in the 17 states that have approved health care rates for 2017.

Insurers lately announced they would exit the Obamacare marketplaces due to the significant financial losses they have incurred during the implementation of the ACA. Thus, 2.3 million Obamacare enrollees—or 19% of all enrollees—could have a “choice” of a single insurer in 2017, according to the Kaiser Family Foundation. In 2016, only about 303,000 enrollees—or about 2% of all enrollees—had a single insurer option, Kaiser found. Next year in Wisconsin,

consumers living in Menominee, Polk, St. Croix and Pierce counties will have the “choice” of purchasing health care from only one insurance company, according to Kaiser.

I am proud to join Senator McCain and others to introduce a bill that would exempt enrollees from Obamacare's individual mandate penalty if they live in a county with fewer than two insurers offering ACA plans. Americans should not be penalized for failing to purchase a product when there is only one or zero companies selling the product where they live.

The American people have been sold a bill of goods. Obamacare marketplaces have been plagued by lower-than-expected enrollments that have driven premiums up even higher and left taxpayers on the hook for costly subsidies. I fear these markets are unsustainable. I thank the witnesses for their testimony and I look forward our discussion.

Opening Statement of Senator Thomas R. Carper
“The State of Health Insurance Markets”
September 15, 2016

Let me begin by thanking our chairman for calling this hearing today and by welcoming our witnesses from around the country.

A little after noon today, a handful of senators – Democrats and Republicans – will gather in a room not far from the Senate floor as we do most Thursdays. For a half-hour or so, we’ll take part in a Bible study led by Senate Chaplain Barry Black, who also happens to be a retired Navy rear admiral. There, we read the Scripture together, we pray together, and we talk about many different things. Invariably, during those conversations, Chaplain Black will ask us how our faith should guide us in the work we do here and at home. It’s a good question.

Almost every week, he reminds us of one of the two greatest commandments – to love our neighbors as ourselves, treating others as we’d want to be treated. He often invokes Matthew 25, which some of us will recall focuses on the ‘least of these’ in our communities. Let me paraphrase it today: ‘When I was hungry, did you feed me? When I was thirsty did you give me a drink to drink? When I was naked, did you clothe me? When I was sick or in prison, did you visit me? When I was a stranger in your land, did you take me in?’

Matthew 25 doesn’t say, ‘When my only source of health care was a crowded emergency room, did you help me?’ It doesn’t say, ‘When I turned 22 and could no longer be covered by my parents health care plan, were you there for me?’ Or, ‘When I could no longer find health care coverage because of a pre-existing condition, did you do anything about it?’ Or, ‘When I couldn’t afford the medicine that would enable me to hold down a job or be the kind of parent my children needed, did you lend a helping hand?’ Or, ‘When I was denied health insurance because I happened to be a woman of child-bearing age or charged an arm and a leg for it, did you go to bat for me?’

Regardless of our faith, I believe that we have a moral responsibility to the ‘least of these who live among us.’ I suspect that most of the people in this room believe that, too. And because our nation’s budget deficit – while greatly reduced – is still too large, we need to find ways to meet that moral responsibility in fiscally sustainable ways. Just about every American president since Harry Truman has sought to find ways to do just that. They believed in their hearts that when people in this country are sick or in need of health care, they ought to be able to see a doctor or nurse or both within a reasonable period of time. I am certain that most, if not all, of our colleagues believe that, too, and I’m sure that most Americans believe it, as well.

So why has it proved so hard to do? For starters, because it’s an incredibly hard thing to do. For another, just about anything we might try can be turned into a 30-second commercial and used as political weapons against presidents or members of Congress who try to do what we all know in our hearts is the right thing to do. I will be the first to acknowledge that the Affordable Care Act is not perfect. It clearly can be improved. When this election is over, we need to go to work to do just that.

Having said that, the Affordable Care Act has sought to better ensure access to health care for all Americans. How? In part by creating state-based health insurance marketplaces where people who may never before have had access to health care now have the opportunity to choose a plan that helps them get healthy and stay that way by participating in large purchasing pools not unlike the ones that federal employees have participated in for decades. The individual mandate that encourages people to purchase these plans is a well-tailored incentive that helps these marketplaces grow and thrive so that insurance companies aren't left with a pool of people to ensure that are largely older, sicker and more expensive to insure.

In this room today, there are witnesses and members of Congress who represent – among others - the states of Delaware, Washington, Ohio, Iowa and Wisconsin. The number of people without insurance in our states, on average, has fallen by almost half since our respective marketplaces opened. For the Delawareans, Washingtonians, Ohioans, Iowans and Wisconsinites who may now take their child to the doctor, this is not only life changing, but it's also life saving. And these life-changing effects aren't being felt only in our states.

Today, because of the Affordable Care Act, 20 million more Americans have health insurance. The uninsured rate is less than nine percent – an all-time low. Americans now have access to free preventive services like cancer screenings and yearly checkups. And the vast majority of people in the marketplaces buy their health insurance for less than \$100 per month. And, this progress has been realized while extending at the same time the life of the Medicare Trust Fund by 11 years.

I find it more than a little ironic that we have been deadlocked in partisan fighting for years over a law that is built upon a couple of sound Republican ideas: health insurance marketplaces and the individual mandate. To my friends on the other side of the aisle – your willingness to walk away from the policies you once championed is dumbfounding, especially when those very same policies are enabling us to begin making a positive difference in the quality of life for so many Americans.

A quick refresher for those who don't remember: Republican Presidential nominee, Governor Mitt Romney, revolutionized health care in Massachusetts by creating an insurance marketplace and requiring residents to obtain coverage. In fact, these ideas go back even further. In 1993, Republican Senator John Chafee introduced legislation that proposed an individual mandate and the establishment of insurance purchasing pools. That bill looked a heck of a lot like the Affordable Care Act we are discussing in this hearing. In fact, it had 20 Republican cosponsors in the Senate, some of whom still serve here today.

Fast forward to 2009, my first year as a member of the Finance and the first year of a new Administration. Our new president called on Democrats and Republicans to try anew to achieve what previous presidents talked about doing for more than a half-century. But, instead of coming to the table and pursuing a productive discussion about how we could expand access to health care for millions of Americans, in the end Senate Republicans chose not to engage. But, the president and the rest of us soldiered on and finally passed this historic law that all of us acknowledged was imperfect.

Like any major new federal program, adjustments are going to need to be made as it is implemented. Unfortunately, we've had a hard time finding many willing partners in this effort.

There used to be times when Republicans and Democrats could come together to make bipartisan health care reforms. Some of us were here when we did just that. We created Medicare Part D, the prescription drug program, and Medicare Advantage. Not long after we had done so, though, we worked together to improve them. Together!

That's not what we've done with respect to the ACA. Time and time again, our Republican friends have blocked funding for proper implementation and commonsense improvements. Republican governors and state legislators in 19 states have refused to expand Medicaid, leaving millions of Americans without coverage and increasing marketplace premiums for millions more. It's a sad state of affairs when it seems sometimes that the only healthcare votes we're allowed are ones to repeal the Affordable Care Act completely, leaving nothing in its place, and leaving Americans with nowhere to turn besides a hospital emergency room.

In a couple of months, Americans will go to the polls to elect a new president and members of Congress. I talk almost every day with Delawareans who await with anticipation for that day to arrive. Once it has, though, and a new Congress as well as a new president have taken their oaths, we need to go to work to make a good idea even better. We can do that. We need to embrace what I call the three 'C's' communicate, compromise and collaborate. We need to embrace those words in the Preamble of the Constitution, 'We the people of the United State, in order to form a more perfect union...' and get to work making the Affordable Care Act better. We can do that. I know that we can and, with the right leadership, I believe that we will. In doing so, we will have confounded our enemies and amazed our friends. 'Let's roll!'

**HSGAC Hearing Statement by Senator McCain
The State of Health Insurance Markets
September 15, 2016**

Mr. Chairman:

There are times when one takes no pleasure in saying, “I told you so”. Or, pride in one’s prescience. Such is the case with Obamacare.

Over seven years ago, when the President and Congressional Democrats traversed the country touting the benefits of what would become the so-called “Affordable Care Act”, my Republican colleagues and I were quick to highlight that their proposals, however well-intentioned they might have been, would result in making things worse. It doesn’t take a policy expert or a Ph.D. to recognize that injecting unprecedented levels of government control into what amounts to nearly one-fifth of the nation’s economy would have devastating consequences.

Regardless of those warnings and a relentless effort by Democrats to demonize those that opposed the law as alarmists and fear-mongers, President Obama continued to promise to the American people that “If you like your doctor, you will be able to keep your doctor, period. If you like your health care plan, you’ll be able to keep your health care plan, period.” The President doubled down on this promise saying “No one will take it away, no matter what.” This of course turned out to be a lie. Ever since, Americans have been hit by broken promise after broken promise, and met with higher costs, less choices, greater uncertainty, and poorer quality of care.

Let me be clear. A choice between a single insurance plan or being financially penalized by the federal government for not buying a plan, is not a true choice. And, it is certainly not the choice and competition that the president sold to the citizens of my state.

Unfortunately for the citizens of my state, our warnings are being realized now—in real time.

Over the last two years, here’s what “keeping your doctor” and “keeping your health care plan” has looked like in Arizona. The first Obamacare casualty came to fruition when Arizona’s Obamacare-established CO-OP, Meritus Mutual Health Partners, closed its doors after the HHS Inspector General found that it was one of the lowest achieving CO-OPs in the country. As a result, 60,000 Arizonans were left scrambling to find a new health care plan. At that point, 11 of the original 23 co-ops nationwide closed despite having received \$2.4 billion in low-interest federal loans—paid by you and me.

Not long after Meritus closed its doors, UnitedHealth announced that it was leaving the Arizona marketplace—after accumulating over \$1 billion in losses in two years as a result of nationwide exchange participation. This left another 45,000 Arizonans not “keeping their plans”. Worse still, another 60,000 Arizonans saw their plan terminated as a result of Blue Cross Blue Shield of Arizona and HealthNet’s announcement they were restricting their Arizona offerings in 2017. Why? Because they too accumulated massive financial losses to the tune of millions of dollars as

a result of Obamacare. Phoenix Health Plans and Aetna also decided to exit Arizona's exchanges, leaving another 32,154 and 13,162 behind, respectively.

Altogether, Arizonans have seen over 210,000 cancellation notices mailed out in less than one year's time. Those notices should have been sent to the White House and every Member of Congress that voted in support of this failed health care law, and because of that support has left hundreds of thousands of Arizonans and millions across the country with fewer choices and higher costs when it comes to health care options.

After Blue Cross Blue Shield of Arizona decided to step in to be sole insurer in Pinal County—previously the only county in America without a single health insurance provider offering plans in 2017—14 of Arizona's 15 counties will only have a single health insurer to “shop” for coverage when open enrollment begins on November 1st. That includes Maricopa County—Arizona's most populous county—impacting more than 120,000 people. This is down from the eight health insurance options that Maricopa County residents had in 2016. As Christian Corieri, Senior Health Care Policy Advisor to Arizona Governor Doug Ducey, stated in testimony submitted for today's hearing, “While Blue Cross Blue Shield has recently decided to offer a plan there at a 50% premium increase, it is only a matter of time until another county faces the prospect of being without an insurer on the exchange.” Indeed, with Cigna serving as the only insurer in Maricopa County and Obamacare coming apart at the seams, I continue to be concerned about uncertainty and instability in the marketplace there.

With this mind, I guess it should come as no surprise that the President had to assemble the CEOs of the major health insurance companies at the White House to convince them that the walls surrounding Obamacare are in fact not falling in.

While many insurers have been forced to exit the marketplace altogether, for the insurers who continue to participate in the exchanges, their only option is to raise premium rates astronomically high in order to cover their losses.

Last year, Arizonans saw the key benchmark plan premium increase to more than double the national average, and unfortunately there is no end in sight. This year, individuals in 13 of Arizona's 15 counties will see premiums increase on average by 51 percent. For some families, this could mean hundreds of dollars more per month out of their paychecks.

As a result, I'm hearing daily from Arizonans throughout the state who are choosing to pay the Obamacare penalty because the cost of health insurance has gotten so out of hand. And what truly breaks my heart, is that Arizonans are now asking the question, “why enroll in Obamacare if you can't afford it or worse still, can't get access to care?” This is what “health care” means for millions of Americans in the world of Obamacare, despite the fact that this is a far cry from what President Obama promised before and after signing his signature health care reform bill into law.

The collapse of Obamacare in Arizona and across the country confirms what Republicans have warned all along: Government-mandated health care is unsustainable. I'm not sure a bill has failed to live up to its name so profoundly as the so-called “Affordable Care Act.” What's clear

is that Obamacare is crumbling, and it is unacceptable to sit on the sidelines and watch it continue to happen, because in the meantime, Arizonans and folks across the country are being left to pick up the pieces. It is imperative that Obamacare be replaced with commonsense solutions that empower patients and doctors – not the government – to take back control of their health care.

I ask that the written testimony of Christina Corieri, Senior Policy Advisor to Arizona Governor Doug Ducey, be included in today's record. Thank you, Chairman Johnson for holding this very important hearing.

**The Committee on Homeland Security and Governmental Affairs
Statement of Mary Taylor,
Ohio Lt. Governor and Department of Insurance Director
Washington, District of Columbia
September 15, 2016**

Mr. Chairman and distinguished members of the committee, thank you for the opportunity to testify before the Senate Homeland Security and Governmental Affairs Committee. My name is Mary Taylor and I am the Lt. Governor of Ohio as well as the Director of the Ohio Department of Insurance. Today, I will provide testimony regarding Ohio's experience related to the Affordable Care Act (ACA) – specifically in regard to premium changes, market shifts and other trends since 2013.

As the Director of the Ohio Department of Insurance, I am responsible for regulating Ohio's insurance market – the 7th largest in the United States. Ohio is home to more than 200 insurance companies and more than 1,600 do business in the state representing \$76 billion in annual premium. In fact, because our market is so competitive, the most recent data shows Ohio's auto and homeowners insurance premiums are significantly below the national average and ranked 12th and 9th lowest respectively¹.

The Ohio Department of Insurance is made up of several divisions designed to help consumers, regulate the industry, and – when necessary – take enforcement action. The Department

¹ According to 2013 data – the most recent available from the National Association of Insurance Commissioners.

leverages these divisions to review all insurance products sold in Ohio, ensure the premium rates are actuarially justified, adequate, and non-discriminatory and assist consumers. The Department ensures companies are solvent while monitoring their conduct in order to protect consumers from practices that do not meet the highest standards.

Our mission at the Ohio Department of Insurance is to provide consumer protection through education and fair but vigilant regulation while promoting a stable and competitive environment for insurers. Our staff works every day to ensure consumers are protected and that the insurance market in Ohio is strong and vibrant. When it comes to health insurance, this mission has become more difficult because of the ACA.

In 2011, shortly after becoming the Director of the Department of Insurance, I commissioned reports to help inform decision making around whether or not Ohio should establish a state-based exchange under provisions in the ACA or if Ohio would be best served by having a federally facilitated exchange. One study (conducted by Milliman) looked at the pre-ACA market in Ohio and compared that to what a post-ACA market might look like. The second study (conducted by KPMG) looked at the work and funding needed to run a state-based exchange.

Both studies offered findings that were sobering for Ohio's health insurance market once the ACA was fully implemented. For one, running a state-based exchange would be costly to the state and ultimately to consumers without providing any additional flexibility to ensure the

exchange best met the needs of Ohioans. Second, Ohio's health insurance market would undergo significant change leaving consumers with fewer choices and more mandated coverage. Finally, because of changes to coverage options in Ohio, premiums were forecast to increase by 55 – 85 percent.

Based on these studies, our administration in Ohio decided not to run a state-based exchange seeing no benefit to burdening our taxpayers with the additional cost and no ability to impact the changes coming to our market that would ultimately drive-up the cost of health insurance. Further, the Milliman study provided strong evidence that premiums would go up in Ohio for consumers and small businesses. But these issues were just some of the challenges states would be facing as provisions of the ACA began to take effect.

In April 2013, I had the opportunity to testify before the U.S. House Energy and Commerce Subcommittee on Health. During my testimony, I discussed Ohio's experience with our high risk pool and the federal government. At the time, states were mandated by the ACA to have high risk pools to help provide coverage to the sickest populations in each state until other provisions of the ACA were fully implemented.

Ohio's high risk pool was administered by a private insurer, funded by the U.S. Department of Health and Human Services (HHS) and regulated by the Ohio Department of Insurance. Because of the unique nature of the arrangement, disputes arose over appropriate premium levels for the high risk pool with HHS refusing to accept the actuarially justified rates that the

Ohio Department of Insurance deemed necessary for coverage as well as disagreements over whether consumers qualified to purchase coverage. The disagreement over coverage eligibility led to a lawsuit and served as an example of the challenges state regulators were facing because of encroachment by the federal government.

I share this example because at the time of my testimony in 2013, I predicted states would face significant challenges as the ACA was fully implemented. I made the case that based on our experiences in Ohio with HHS on disputes over our high risk pool – disputes that would have never occurred prior to the ACA becoming law because states had previously always had authority in these areas – these types of problems would only increase as the law took effect.

In the summer of 2013, the Ohio Department of Insurance reviewed health insurance plans to be sold on the federal exchange for the first time. Any insurance company selling these products in Ohio must file those plans for review and approval with the Department of Insurance. Following the Department's review, we concluded that average individual premiums for health insurance products sold on the federal exchange for coverage in 2014 would increase 41 percent from the previous year².

The information received widespread attention that year considering the significant change in cost coupled with it being the first year the exchanges were open to consumers. However,

² Comparison based on premium data collected by the National Association of Insurance Commissioners (NAIC) for Ohio companies compared to final rates approved by the Ohio Department of Insurance in 2013.

much of the push-back to the data we released from the federal government and supporters of the ACA stemmed from access to subsidies. They argued consumers would rarely pay for these large increases because they would have access to large, federally funded tax subsidies to offset the cost.

However, as I – and many others around the country – pointed out those tax subsidies must be funded. The hundreds of billions of dollars in subsidies being spent across the country are taxpayer dollars. And some of the funding is pulled directly from the insurance industry to help make the system work. The imbalance in the system is further exacerbated by skyrocketing premiums. HHS put out a report in August of this year showing the faster premiums increase on the federal exchange, the more consumers will qualify for subsidies. The HHS study showed that a 50 percent increase in premiums for 2017 would allow more consumers to access the subsidies compared to a 10 percent increase in premiums³.

Such a model is unsustainable and cannot stand under its own weight. That was the argument I made at the time, but without some of the realities we now know those arguments were often dismissed as hysteria or obstructionism. But as the ACA continued to be implemented, more of those concerns were demonstrated to be well founded. Just look at the current state of co-ops around the country.

³ Information based on HHS report: *The Effect of Shopping and Premium Tax Credits on the Affordability of Marketplace Coverage* released on August 24, 2016.

Under the ACA, the co-op program was created to help foster competition across the country. It was designed to help offer consumers more choices and in so doing, help lower the cost of insurance by making the industry adjust to added competition. However, I argued at the time that government should not be in the business of creating competition in a free-market environment. The foundation upon which a free-market system is built is freedom from government interference.

In Ohio, a co-op under the name Coordinated Health Mutual applied for and eventually received a license in 2014. It was unable to offer coverage on the first year of the exchange because it didn't receive a license soon enough. Ultimately, that delay probably helped the co-op avoid some of the tumult experienced by insurers during the first year of coverage and in our estimation helped ensure it could sell coverage for as long as it did. However, like many of the co-ops around the country, it fell victim to skyrocketing costs and a lack of revenue earlier this year.

In May, the Department of Insurance took control of Coordinated Health Mutual in order to run out the claims by its enrollees and liquidate the entity. Of the 23 original co-ops set-up across the country, only seven still remain in operation. The failure of these federally funded entities has cost taxpayers billions of dollars and left consumers – like those in Ohio right now – facing uncertainty as well as disruptions in coverage and treatment.

These realities are so frustrating because they have all been preventable. Commissioners around the country have been voicing concerns for years over the implementation of the ACA. We have regularly communicated to HHS that rules are too vague in places where specificity is needed and too prescriptive in places where flexibility is needed. A one-size-fits-all approach to health care doesn't work. The simple truth is that what Wisconsin needs is not the same as what Ohio needs or Mississippi or California, etc. States need the tools and the autonomy to address these important issues on a more local level.

With the failures of the co-op program and the uncertainty insurers are now facing due to languishing federal cost containment programs, the future is even bleaker than ever when it comes to the ACA. Risk adjustment, risk corridor and reinsurance programs were all created under the ACA to help insurers weather the initial years of ACA implementation. Those programs have fallen short of the promises made in 2010 and – along with the mandate-heavy coverage now required by the ACA – are having an impact on consumers and state insurance markets especially when it comes to the amount of competition.

Prior to full implementation of the ACA, Ohioans benefited from a large selection of insurance carriers, with more than 60 companies selling health insurance products in Ohio. Based on the filings the Ohio Department of Insurance just reviewed and approved for the 2017 coverage year, Ohio's insurance market is set to go through more significant changes on top of those already experienced in the past few years that will negatively impact consumers.

In 2016, 17 health insurers sold products on Ohio's federal exchange during open enrollment. In 2017 – assuming all companies approved to sell on the exchange by the Ohio Department of Insurance enter into contract with HHS – only 11 companies will offer exchange products. This dramatic decrease in participation can be put into better perspective when looking at a county-by-county comparison of Ohio.

In 2016, every one of Ohio's 88 counties had at least four insurers selling exchange products during open enrollment. In 2017, 19 counties will have just one insurer selling exchange products and 28 counties will have just two⁴. This is not the competition and choice the country was promised in 2010 – to say nothing of the rate increase that Ohio has seen since the implementation of the ACA.

Based on the final rates approved for 2017, the average premiums for individuals buying on Ohio's federally run exchange have gone up 91 percent since 2013⁵. A near doubling of the premium will undoubtedly harm some Ohio consumers as open enrollment gets underway later this fall. Yet, the passage of the ACA came with assurances that costs would go down, consumers would have more choice and if you liked your doctor and wanted to keep your doctor you could. Unfortunately, that is all becoming more and more difficult for consumers.

⁴ Ohio county-by-county data found in attachment to testimony.

⁵ Premium comparisons for Ohio found in attachment to testimony.

As the cost of offering health insurance becomes more expensive for insurers and with the companies facing losses from selling exchange products which is compounded by a lack of adequate cost stabilization mechanisms as originally promised by the federal government, they have to find ways to stay competitive.

Because health insurance under the ACA's more stringent requirements is more expensive, provider networks in Ohio and across the country are becoming narrower. The more a health plan can narrow a provider network, the more ability that plan has to contain costs and remain competitive. The result leaves many Ohioans to shop on Healthcare.gov this fall facing fewer options and coverage that may not include their preferred doctor. And in some cases the nearest hospital may not be in their insurer's network. Putting aside rising premiums and the exploding subsidy costs needed to offset higher premiums, this is an issue that has real and significant impacts on consumers.

At the Ohio Department of Insurance, we have worked to address these issues exacerbated by the ACA by ensuring consumers have access to better, more timely information when it comes to health insurer networks. Insurers are required to update their information in a more timely fashion as well as provide safeguards to protect the consumer from making decisions based on outdated network directories.

These changes – implemented in Ohio before CMS could address the problem – also make it easier for consumers to access information as to whether their provider is in network while

they shop. These efforts, however, cannot change the fact that some Ohioans may purchase a plan this fall that does not include their doctor or their hospital.

I think most of us agree Americans should be able to purchase health insurance without facing barriers because of pre-existing conditions. We agree more can be done to improve the system to increase accessibility and promote better outcomes for patients. However, the ACA is not living up to promises made in regard to what our health care system would look like long-term.

We need to increase access by reducing costs instead of forcing everyone to buy more expensive coverage that in many cases they don't need or don't want. We need to empower states to design systems best suited for their populations instead of forcing one-size-fits-all mandates that in some areas are simply unworkable. We need to decentralize the power of Washington bureaucrats who – quite frankly – do not understand insurance or how to regulate it as my colleagues and I and our predecessors have done for decades.

In Ohio, we have ideas to help improve our health system without destroying the free market as the ACA has done. We believe there is a better, more inclusive way to design reforms that increase access without driving up costs, but we need the flexibility to do it. It is my hope that with different leadership and the help of Congress, states can once again have the power to implement positive change.

Thank you for the opportunity to testify before the committee and I am happy to answer any questions you have.

ATTACHMENT

Comparison 2017 to 2013 Weighted Average Annual Premium

Comparison 2017 to 2013 Weighted Average Annual Premium

Individual Market

	Weighted Average Annual Premium
2013*	\$2,650.17
2017**	\$5,065.30
% Change	91%

Small Group Market

	Weighted Average Annual Premium
2013*	\$4,041.66
2017**	\$7,847.92
% Change	94%

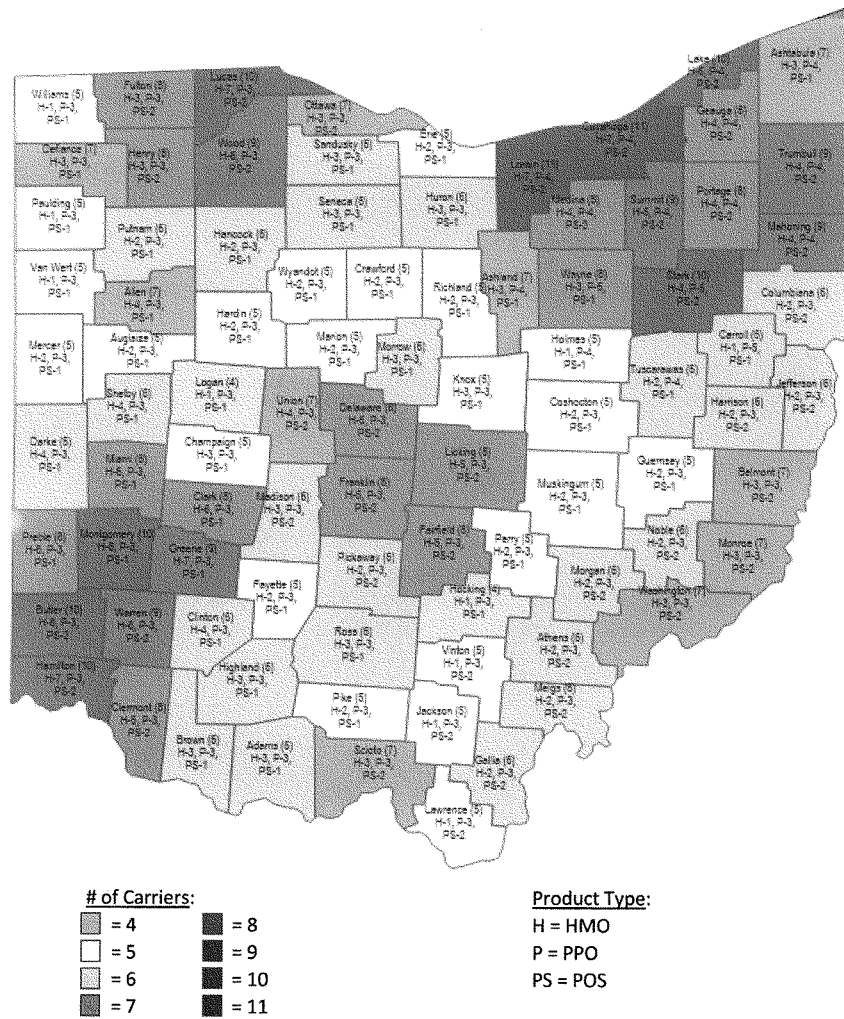
*2013 Weighted Average Annual Premium was calculated from issuer reported annual premium and number of covered lives in the NAIC Supplemental Health Care Exhibit for 2013, Comprehensive Health Coverage. Issuers with zero premium or zero lives were removed from the census. Average weighted by number of lives as reported by the issuer.

**2017 Weighted Average Annual Premium was calculated from the monthly rates in the 2017 Rate Data Templates as of 8/23/2016 and weighted by the member months assumed by the issuers listed in the URRT. Trend was not incorporated into the calculation. Average weighted by member months assumed by the issuer.

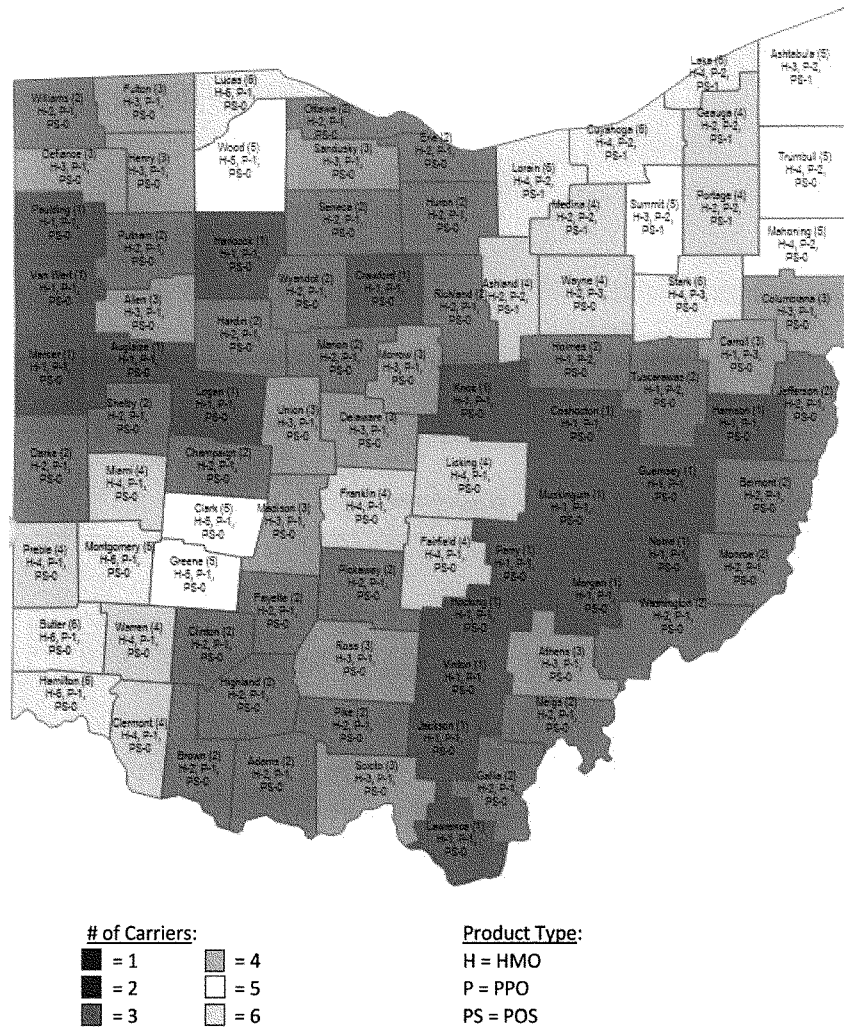
ATTACHMENT

County Comparison 2017 to 2016 Insurer Offerings in Ohio

2016 PY Individual Market On-Exchange Availability



2017 PY Individual Market On-Exchange Availability as of 8/16/2016



**Testimony of
Deputy Commissioner J.P. Wieske, on behalf of the
Wisconsin Office of the Commissioner of Insurance**

**Before the
U.S. Senate Committee on Homeland Security and Governmental Affairs**

**Regarding:
The State of Health Insurance Markets**

**September 15, 2016
342 Dirksen Building**

Good morning Chairman Johnson, Ranking Member Carper, and distinguished members of the subcommittee. My name is J.P. Wieske and I am the Deputy Insurance Commissioner for the Wisconsin Office of the Commissioner of Insurance (OCI). I have been with OCI since October of 2011. As part of my duties I have been involved with a number of health insurance issues including serving on the state's high-risk pool board, working with our state legislature, and assisting with the implementation of the Affordable Care Act (ACA).

Thank you for the opportunity to testify on the state of the Wisconsin health insurance market. Before describing the current state of the market, it is important to understand what it looked like prior to the passage of the ACA.

As a regulator, Wisconsin has been traditionally known as a state with tough but consistent rules. We were one of the first states with a number of market and consumer protections that eventually became models for the National Association of Insurance Commissioners (NAIC) and were subsequently included as part of the ACA. These included independent external review, standardized applications, coverage for adult dependents, cancer clinical trials, guaranteed renewability in the small group market, and a robust review of the market conduct of our insurers. Our financial review of companies has been led by highly experienced staff. In short, we ensured, and continue to ensure, that insurers in the health insurance market deal with consumers fairly and maintain the financial means to pay consumer claims.

Pre-ACA, the Wisconsin market was certainly not the least expensive in the country; however, we typically landed in the lowest third of states. While the medical care provided in Wisconsin is high quality, it is not inexpensive. The medical costs in our market are relatively higher than other states; in fact, a U.S. Government Accountability Office (GAO) report released in the early 2000s named Wisconsin cities as 8th of their 10 most expensive medical areas in the country. Our competitive health insurance market ensured that Wisconsin consumers paid relatively low rates despite the relatively high medical costs.

Wisconsin consumers in both the individual and small group markets had a large number of insurers and plans to choose from. They could choose from large national companies or small

regional insurers, a managed care plan with a narrow network or a plan with limited managed care and a broad network, or from a for-profit company or not-for-profit company. In some areas of the state consumers could choose to participate in one of our two existing co-ops.

For consumers that could not qualify for private coverage, Wisconsin had a high-risk pool, the Wisconsin Health Insurance Risk-Sharing Plan (HIRSP). HIRSP provided comprehensive coverage to consumers with the ability to choose any medical provider practicing in Wisconsin. It was funded by premiums from consumers, assessments on insurers, and contributions from medical providers. Consumers could choose from a variety of plan options, and for the most impoverished consumers, further subsidies were made available. The cost of coverage closely mirrored the cost of private coverage in the state.

In short, pre-ACA, Wisconsin had a well-functioning health insurance market that provided a means for consumers with serious medical conditions access to comprehensive, affordable coverage, along with subsidies available to offset the cost.

The ACA made a number of changes to the rules governing health insurance markets across the country. These “one-size-fits-all” changes have impacted rates, consumer choice, and the ability for a free market to operate.

ACA Impact on Wisconsin Health Insurance Rates

With the enactment of the ACA came guaranteed issue, additional coverage mandates, and the elimination of HIRSP, the state’s high-risk pool. Wisconsin insurers were quickly faced with an uncertain influx of individuals with serious health conditions; 20,000 alone from HIRSP. They were also faced with vague regulations from the federal Department of Health and Human Services (HHS) that changed constantly and were not communicated consistently from HHS. In short, insurers wanting to continue to participate in the Wisconsin health insurance market ultimately had no choice but to increase rates. The net result was that Wisconsin consumers paid more for coverage, including those individuals who previously received coverage through HIRSP.

To offset the increased risk insurers would take on under the ACA, the HHS issued regulations creating the risk adjustment, reinsurance, and risk corridor programs, i.e., the “three Rs.” Each of these programs was to have either state components or to be managed entirely by the states. However, in one of their first acts of ignoring state concerns, HHS changed course and modified the regulations to allow the federal government to take over the “three Rs” from the states. Unfortunately for Wisconsin consumers, this change would negatively impact them as insurers struggled to plan for and capture their estimated risk and receive their fair share of funding from these programs. HHS continues to struggle to manage these programs in a way that fairly compensates insurers taking on a significant portion of the risk.

Rising health care costs and adjusting to the fundamental market changes the ACA imposed both continue to drive up the cost of health insurance. These pressures are further exacerbated by uncertainty related to the risk pool, federal funding, and federal regulations that constantly change without significant notice. Insurers are operating in a turbulent environment and many are struggling to remain profitable and offer affordable coverage that meets consumer needs.

Detailed Impact of the ACA on Wisconsin Health Insurance Rates

In an effort to prepare consumers for the coming market, OCI issued a press release in 2013 to highlight the expected increases. The chart used in the release is below:

Percent Increase From Pre to Post 2014, Average Per Area								
Age	Milwaukee	Eau Claire	Green Bay	Madison	Appleton	Wausau	Kenosha	La Crosse
21	78.11	68.75	53.73	124.85	54.18	77.44	37.59	88.53
40	40.85	48.35	53.73	73.43	36.75	35.03	15.15	41.58
63	45.48	58.12	22.54	70.04	32.01	26.07	9.72	37.29

As you can see, the increases varied from a low of almost 10 percent for a 63-year-old in Kenosha to almost 89 percent for a 21-year-old in La Crosse. For purposes of comparison, we used a \$2,000 deductible plan pre- and post-ACA. Male and female rates were averaged pre-

ACA. In many cases, the post-ACA plan had a higher deductible but we attempted to match the plan design close as possible. When multiple plans were available, the rates were averaged.

Below are the premium tables used to develop the percentages.

	Milwaukee Pre 1/1/14	Eau Claire Pre 1/1/14	Green Bay Pre 1/1/14	Dodgeville Pre 1/1/14	Madison Pre 1/1/14
21	\$155.98	\$176.79	\$162.71	\$102.41	\$116.95
40	252.07	257.02	240.85	172.38	193.78
50	376.72	358.56	364.56	266.39	282.66
63	563.70	556.99	579.86	408.21	449.88
Family	716.57	753.46	682.23	466.62	546.25

	Milwaukee Post 1/1/14	Eau Claire Post 1/1/14	Green Bay Post 1/1/14	Dodgeville Post 1/1/14	Madison Post 1/1/2014
21	\$ 277.81	\$ 298.34	\$250.13	\$ 311.05	\$ 262.96
40	355.04	381.28	319.67	397.52	336.06
50	496.16	532.83	446.74	555.53	469.65
63	820.09	880.69	738.39	918.21	764.96
Family	1,062.90	1,141.44	957.00	1,190.08	1,001.22

It may be important to note that the impact on our HIRSP members—our most vulnerable citizens—was more pronounced. Many HIRSP members received significant subsidies for their coverage through HIRSP, could choose from any medical provider in Wisconsin, and had a variety of plan choices. Their coverage was replaced with more expensive coverage, limited plan design options, and limited access to their choice of providers.

Since 2014, the rates have continued to increase annually. The years 2015 and 2016 saw relatively moderate average increases of almost 3.8 percent and 8.3 percent, respectively, though many consumers received much higher or lower increases depending on their particular plan. The on-Exchange increase in 2017 averages roughly 16 percent with a high of 37 percent and a decrease of more than 10 percent. Wisconsin's increases are likely more moderate than what you will see in other states due to the highly competitive nature of our market. It takes 17 insurers to comprise an 80 percent share of the individual health insurance market. That said, the challenges imposed by the ACA have led to individual market exits which reduce consumer choice and, if continued as a trend for future years, threatens the ability of our market to prevent rates from

reaching levels seen in other states. Our competitive market is a saving grace for consumers as a means for holding down what would be even higher increases. Insurers in our state are fighting an uphill battle to adhere to ACA regulations and still remain viable enough to offer competitive products.

Consumer Choice and Interfering with a Free Market Model

So far, for plan year 2017, Wisconsin has had several insurers exit the individual market completely, leave the Exchange, or reduce the number of counties they are willing to serve. As a result, there are thousands of individuals enrolled in a plan that is offered by an insurer that will not be available to them in 2017. The HHS solution is to “auto re-enroll” these individuals into a new plan with a new insurer. While federal regulations indicate that this can only occur if permitted under state law, HHS is unwilling to change course in light of several states, including Wisconsin, indicating that the auto re-enrollment process violates several state laws. Consumers who do not act within an undefined timeframe will be assigned to a new plan with a new insurer, not of their choosing, and will receive a premium invoice from their new insurer. Consumers will be confused and forced to forgo paying their premium if they choose to refuse the assigned coverage.

Auto re-enrollment is impacting consumer choice at the market level as well. HHS is cherry picking which insurers will get additional business. This is interfering with a free market which has successfully offered affordable choice meeting consumer demand. HHS is adding lives to insurers who, in some cases, will be given a leg up in growing their business and for others unanticipated additional lives may result in financial ruin. When insurers are made aware two months out from open enrollment that several thousand lives are now anticipated to be auto-enrolled with them, they are faced with significant rating and operational considerations, some of which may be too great to overcome on such short notice.

A Look Ahead; Impact of Transitional Plans

It is important to remember the volume of consumers covered under transitional plans in the individual and small group markets. In Wisconsin, as of December 31, 2015, there were 203,587 covered lives under transitional plans. In 2018, when these plans are no longer available,

consumers, in particular employers, will experience rate increases as they are forced to purchase coverage meeting all of the ACA requirements.

Conclusion

In conclusion, Wisconsin had a strong health insurance market offering products responding to consumer needs prior to the ACA. Since the passage of the ACA, insurers struggle to continue to stay viable and offer affordable coverage to Wisconsin consumers. Rates continue to increase and an insurer's ability to predict risk from year to year remains difficult in light of an unstable federal regulatory environment where the rules keep changing without attention to the diverse insurance markets that exist across the country. Each state is unique. Forcing health insurance markets into a standardized set of federal regulations adds an unnecessary layer of complexity that stifles both an insurer's and state regulator's ability to be innovative and have the flexibility necessary to meet consumer needs.

Testimony for the Senate Committee on Homeland Security and Governmental Affairs

The State of Health Insurance Markets

September 15, 2016

Nick Gerhart, Iowa Insurance Commissioner

Introduction

Good afternoon Chairman Johnson, Ranking Member Carper and esteemed members of the committee. My name is Nick Gerhart and I am the Insurance Commissioner of the State of Iowa. I have held this position since January 2013 and have worked extensively at the state level to comply with Federal law on the implementation of the Affordable Care Act. I am here to speak with you today about Iowa's health insurance markets and issues affecting health insurance markets as a whole.

ACA Implementation

Prior to the Affordable Care Act (ACA), Iowa had one of the highest health care insurance coverage rates in the nation (less than 9.7% uninsured rate¹). The individual health insurance market faced challenges prior to the ACA, such as rate increases, exclusions, and denial of coverage, but the market functioned for those able to obtain coverage. The state operated a state high-risk pool for citizens unable to obtain coverage, and the state has left that pool open to this day to provide another coverage option for Iowans. The high-risk pool coverage is expensive, but it provides a viable option for coverage for those Iowans who were unable to obtain other coverage.

The ACA was created with the principal goals of improving health care quality, access, and affordability for all Americans. In part, the law has achieved some of these goals, for example, the national uninsured rate decreased by nearly nine million from 2013 to 2014.² While many states had higher rates of uninsured citizens, Iowa traditionally had one of the lowest uninsured rates in the country. **However, the uninsured rate in Iowa did improve since implementation of the ACA and fell from nearly 248,000 in 2013 to 189,000 in 2014.³** It is important to note that the increase in the number of Iowans obtaining health coverage is due to the implementation of Medicaid expansion. Iowa has actually seen a decrease in its numbers of people purchasing individual insurance. In 2013, 189,594 Iowans purchased individual insurance coverage. At year-end 2015, 184,744 Iowans purchased individual health insurance coverage either through the marketplace or outside of the marketplace. And significant debate remains about whether improved access could have been achieved through much more efficient market mechanisms.

¹ Available at: <http://www.hhs.gov/healthcare/facts-and-features/state-by-state/how-aca-is-working-for-iowa/index.html#>.

² U.S. Census Bureau. See Table A-1; available at: <http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf>

³ U.S. Census Bureau. See Table A-1; available at: <http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf>

The ACA implemented market reforms requiring insurance companies to cover people regardless of their pre-existing conditions. This change permitted many people with serious health conditions to gain access to health insurance. The ACA also made advanced premium tax credits available to help lower the cost of Health Insurance Marketplace premiums for those who qualify. Nearly 85 percent of the 55,000 Iowans receiving coverage through the Marketplace in 2016 qualified for these tax credits.⁴

The ACA's changes to the Medicare and Medicaid programs are often overshadowed by the commercial market reforms and the Health Insurance Marketplace. The changes in these programs, however, are also worth mentioning as movement towards the ACA's principal goals. Iowa's largest health insurance company created accountable care organizations (ACOs) that were modeled after the ACA's Medicare ACOs. Wellmark Blue Cross Blue Shield ACOs cover fully insured members and reportedly generated \$35 million in health savings in 2015.⁵ "The 13 health systems participating in the ACOs achieved savings by reducing hospital readmissions by more than 22 percent, inpatient admissions by almost 8 percent, and emergency department visits by nearly 4 percent, according to Wellmark."⁶ Iowa is also a state that implemented our own bipartisan, tailored version the ACA's Medicaid Expansion. This program, known as the Iowa Health and Wellness Plan, currently provides coverage to over 150,000 low-income, childless adults, many of whom were previously uninsured.⁷ This program integrates health ownership with modest premium contributions required at certain income levels above 50 percent of the federal poverty level and as a guiding principle. The Iowa Health and Wellness Plan since April 1, 2016 has been delivered through a managed care payment model.

The Health Insurance Market in Iowa and Challenges of the ACA

While the ACA has increased health coverage for Iowans overall, the costs of health care have hit the pocketbooks of Iowans hard as rates have increased every year since 2014. Generally, healthier Iowans have subsidized the costs of increased access for sicker Iowans through higher insurance costs. As background, Iowa has a population of just over 3 million people and nearly 66 percent of Iowans have access to employer-sponsored insurance.⁸ Less than 7 percent, or about 190,000 Iowans, purchased individual coverage prior to the formation of the Health Insurance Marketplace in Iowa. Of those who purchased individual coverage, nearly 78 percent purchased their policies from one company, Wellmark, Inc. (Wellmark)⁹ In calendar year 2014, when Iowa's State Partnership Health Insurance Marketplace became a source of health care

⁴ See U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation. See 'State Level Data Excel Tables' available at: <https://aspe.hhs.gov/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report>. Interestingly, in an IID survey of Marketplace carriers, carriers self-reported a total of only 47,813 enrolled members by June 30, 2016.

⁵ Business Record, July 27, 2016, available at: <http://www.businessrecord.com/Content/Health-Wellness/Health-Wellness/Article/Wellmark-ACOs-generate-35M-in-health-savings/174/836/74119>.

⁶ Business Record, July 27, 2016, available at: <http://www.businessrecord.com/Content/Health-Wellness/Health-Wellness/Article/Wellmark-ACOs-generate-35M-in-health-savings/174/836/74119>.

⁷ Iowa Department of Human Services, Improve Iowan's Health Status, p.3-28 available at: http://dhs.iowa.gov/sites/default/files/15-6_Improve_Health_Status.pdf.

⁸ This percentage of health insurance coverage is based on the health insurance market in 2010-2011, available at: <http://www.epi.org/publication/bp353-employer-sponsored-health-insurance-coverage/>.

⁹ National Association of Insurance Commissioners, I-Site Supplemental Health Care Exhibit.

coverage, Wellmark did not join. Also in 2014, grandfathered and transitional plans remained available and many kept their previous coverage. As a result, enrollment numbers in Iowa's Marketplace were low with only 25,560¹⁰ people purchasing Marketplace policies in 2014. Wellmark declined to join the Marketplace in 2015 and 2016 and continues to provide coverage to over 65 percent of the individual health insurance market as many Iowans have kept their grandfathered and transitional plans.¹¹

As mentioned above, the costs of health care in Iowa have increased every year since 2014. During the first year of Marketplace implementation, many insurance policies were underpriced, in part due to a lack of claims history on the uninsured population, pent-up demand, and lack of movement from grandfathered and transitional policies. The insurance industry found pricing for this population very challenging. Based on the Marketplace claims experience from 2014 and 2015, federal regulators and insurance carriers found that the population utilized healthcare in a manner similar to the nation's Medicaid population. To be more specific, **the previously uninsured population is, on average, sicker and has a higher level of healthcare utilization than the population who receive commercial coverage through their employer sponsored plans.** With the claims experience available, carriers realized premium increases were necessary and I will discuss those rate increases in a moment.

Changes mandated by the ACA and some actions of Congress also directly contributed to these increases. The single risk pools in the ACA Marketplaces were designed to spread the costs of health care across all members of the risk pool. **In Iowa, however, low enrollment in the Marketplace has resulted in a few members with high cost claims driving up the premiums for the entire group.** Aetna¹², a carrier on Iowa's Marketplace since 2014, reported that "...the top 5 percent of spenders drive nearly 60 percent of the cost."¹³ This concentration of risk and high utilization population is driving significant rate increases across the carriers' individual risk pools. The ACA does not provide adequate flexibility for a carrier to shield the risk pool from the cost of catastrophic claims.

Additionally, with the ACA's elimination of annual and life time limits on health care costs, the costs of large claims have greatly increased. Aetna reported that claims costing more than \$50,000 have increased by 38 percent.¹⁴ Wellmark reported that percentage of claims costing more than \$100,000 increased by 200 percent.

The Marketplace special enrollment periods (SEP) have also contributed to increasing health care costs. Carriers in Iowa and nationally have noticed that people who enroll during

¹⁰ The number represents the number of non-Medicaid persons on Iowa's Marketplace in 2014. There were an additional 20,808 Medicaid Expansion members receiving Marketplace coverage and because the state Medicaid program paid premiums for these members, the numbers have been excluded.

¹¹ Percentage represents numbers through 2015.

¹² Aetna purchased Coventry and began Marketplace operations in Iowa in 2016; prior to Aetna's purchase Coventry operated as Coventry Health Care of Iowa, Inc. in 2014 and 2015.

¹³ Iowa Rate Hearing transcript, Dale Mackel (Aetna) testimony, p.12.

¹⁴ Iowa Rate Hearing transcript, Dale Mackel (Aetna) testimony, p.12.

SEPs cost nearly double the amount of those who enroll during open enrollment.¹⁵ Wellmark, for example, received one member during a SEP whose health care coverage costs nearly \$12 million annually and caused roughly 10 percent of the rate increase for 2017.¹⁶

The Rising Costs of Healthcare

In Iowa, the rising costs of health care has resulted in carriers requesting premium rate increases that were significantly greater than before the implementation of the Marketplace. In fact, in 2012 and 2013, the average premium rate increases among health insurance carriers was 5.48 and 5.95 percent respectfully.¹⁷ For calendar years 2016 and 2017, however, Wellmark received rate increases of 26.5 and 42.6 percent respectively for its ACA-compliant, off the Marketplace plans.¹⁸ Aetna received rate increases of 19.8 and 22.58 percent for calendar years 2016 and 2017 respectively. These increases were spread among the ACA compliant plans offered both on and off the Marketplace.¹⁹ **For calendar year 2017, Iowa has carriers that have scaled back on the amount of plans they will offer and the areas where they will provide services. Iowa also had one state-wide carrier, United Healthcare of the Midlands, completely withdraw from the Marketplace without even requesting a rate increase. Finally, Iowa was the first state to face a failed health care cooperative, Co-Opportunity, in late 2014.** The Iowans on that plan were forced to quickly secure other coverage in 2015. Due to the co-op failure and United Healthcare withdrawal, Iowans looking for coverage may have limited options on the Marketplace in 2017.

In my role as Iowa's Insurance Commissioner, I have to balance the needs of Iowa's consumers against the solvency of an insurance carrier. As previously described, several provisions of the ACA have had significant impacts on Iowa's health insurance premium rates and pricing. In reviewing rate increase requests, I facilitate a public hearing²⁰, review consumer comments, and study the actuarial reports from consulting actuaries and internal actuarial staff from the Iowa Insurance Division.²¹ If I find that there is no evidence that the proposed rate filings are discriminatory or excessive under Iowa statute, the rate increases are approved.

The Need for Reform

The levels of rate increases cannot continue to be sustained by Iowa's consumers. If this pattern continues over the next few years, I have serious concern about whether Iowa's consumers will be able to afford Affordable Care Act policies. We are essentially placing consumers in situations where they must choose between healthcare coverage and paying their mortgage or

¹⁵ Wellmark publication, "Understanding Proposed 2017 Premiums, How Wellmark is Addressing Costs." May 2016.

¹⁶ Available at: <http://www.desmoinesregister.com/story/news/health/2016/05/12/wellmark-plans-38-to-43-increases-some-customers/84277758/>.

¹⁷ Information from IID healthcare insurance actuary. Percentages are not based on weighted averages of individuals but rather the increases received for each company.

¹⁸ Available at: <http://www.iid.state.ia.us/node/11419107> and <http://www.iid.state.ia.us/node/14060795>.

¹⁹ Available at: <http://www.iid.state.ia.us/node/11419109> and <http://www.iid.state.ia.us/node/14060792>.

²⁰ In 2016, hearings were only required when rate increase requests exceeded 6.4 percent. See IAC 191-36.20(3).

²¹ The Iowa Insurance Division is one of the few DOI's that utilize both internal and external actuarial staff in the rate review process. This is done to ensure accuracy.

rent. I also have serious concerns about whether carriers will continue to participate in Iowa's Marketplace. **In its current form, the ACA has turned a previously stable Iowa market with some of the lowest premiums in the nation, into an unstable and teetering market with extremely high premiums. Federal legislative changes are necessary to ensure the continued viability of the Health Insurance Marketplaces. Specifically changes are necessary to the 3R's programs and to the single risk pool. Changes are also needed to address the costs of healthcare.** There is little a state can do in isolation to reform their health insurance market. Without changes from the federal level, in collaboration with the states, individual states will be in the difficult position of watching a potential collapse of the individual health insurance market.

The 3R's programs.

I believe an area of legislative focus needs to be the 3R's programs. The ACA's risk corridors, risk adjustment, and reinsurance programs, collectively known as the 3R's programs, were designed to protect against the impacts of excess loss or gains, adverse selection, and costs of catastrophic claims.

As you may know, the risk corridors program intended to set a range of allowable gains or losses sustained by any qualified health plan (QHP). The QHPs with less claims amounts would essentially pay the QHPs with greater claims amounts. The intention of this program was not realized because the aggregate losses were so significant. In 2014, the QHPs requested a total of \$2.8 billion in risk corridors pay-outs, but only received \$360 million.²² In December 2014 Congress passed the continuing resolution budget act requiring that the risk corridor be budget neutral. Due to the shortfall in risk corridor payments into CMS, QHP carriers received just over 12 cents for each dollar they thought they would receive. In Iowa, this was detrimental to the co-op and contributed, among other factors, to its eventual insolvency. The state of Iowa is now involved in litigation with CMS over many issues as it pertains to the dissolution of the Iowa based co-op, but a main issue is the recovery of risk corridor funds. **The risk corridor program is set to expire in 2016 and we do not recommend that it be continued in the future.**

The risk adjustment program was designed to redistribute funds from plans with lower-risk consumers to plans with higher-risk consumers; this is determined from each consumer's risk score relative to the statewide average. The program is available for all ACA-complaint plans available both on and off the Marketplace. Although this program may have worked as intended, in Iowa, **this program may result in the unintended consequence of pushing narrow network carriers out of the Marketplace.** In 2014 and 2015, plans that tried to control costs with narrow networks paid the larger broad-based PPO plans. Aetna, a carrier with narrow networks, paid over \$9.2 million and over \$10.8 million in 2014 and 2015 respectfully.²³ While Wellmark, a carrier with PPO plans, received over \$4.6 million and over \$16.6 million for its off the Marketplace plans in 2014 and 2015 respectfully.²⁴ Iowa's Marketplace cannot be sustainable if the carriers who choose to control costs with narrow networks (that are deemed to

²² Numbers received from IID's healthcare insurance actuary.

²³ Numbers received from IID's healthcare insurance actuary.

²⁴ Numbers received from IID's healthcare insurance actuary.

be 'adequate' by CMS through the QHP certification process) are required to pay those carriers who offer broad-based plans. This program may have contributed to Aetna's withdrawal from 11 of the 15 states where it participated in the Marketplace. Iowa was one of four states where Aetna chose to continue operations.²⁵ We do have concerns, however, about Aetna's continued participation in Iowa's Marketplace if there is not legislative reform in this area. As CMS recently released draft rules in attempts to address the short-falls of the risk adjustment program, we are hopeful that carriers find the reforms adequate.

The final 3R program is the reinsurance program. This program requires all health insurance carriers, including small group and large group carriers, to provide funds to ACA-compliant individual plans that enroll higher-cost individuals. In Iowa, this program works as envisioned. Without this program, premiums in the individual ACA-compliant market would have been approximately 10 percent higher in 2014, 6 percent higher in 2015 and 4 percent higher in 2016.²⁶ This program is set to expire after 2016, thus causing rate increases over the same time period. In other words, if a carrier is receiving a 10 percent reinsurance credit in one year due to this program, premiums will increase by the same amount when the program expires.

Legislative changes should be considered to allow this program to continue in a manner that protects individual state interests.

The Single Risk Pool.

Federal legislators should also consider reviewing how an effective high-risk pool could offer more predictable single risk pool pricing. As stated earlier, a small number of claims in Iowa are driving a significant amount of the rate increases. This is adverse selection by definition. Adverse selection occurs when more people with higher healthcare expenses buy insurance than people with lower health care expenses. When Marketplace coverage became available in 2014, many people who were previously uninsured and who had pent-up demand for services bought Marketplace plans. Additionally, far fewer than expected healthy, young Americans signed up for Marketplace coverage. Carriers initially priced their plans to include the younger, healthier population. Without this population to offset the costs of those with higher healthcare costs, carriers incurred higher costs of claims. Recall that for Aetna, the top 5 percent of high cost members are responsible for 60 percent of the cost of claims. The higher costs of claims results in carriers needing to raise premium rates in the subsequent years. The increased rates, in turn, deter the younger, healthier population from enrolling despite the penalty for going without insurance.

Iowa had a state high-risk pool that is still in effect today. Looking at using that as a mechanism to cover the most needy and chronically ill people may be worth exploring.

High-risk pools effectively spread the cost across society by covering high cost claims, rather than costs being incurred by the individual insurance carrier, and spread to the members of the pool. If states were allowed to place high-cost consumers into a single, national high-risk pool, the costs of those who remain in the Marketplace would become more stable. A high risk pool

²⁵ <http://www.usatoday.com/story/money/2016/08/16/aetna-obamacare-affordable-care-act-exchanges/88825798/>.

²⁶ Numbers received from IID's healthcare insurance actuary.

should be designed to address the problems with the previous federal high-risk health insurance pool including: 1) ensuring enough funding is available to cover the consumers health care costs; 2) designing a coverage option that provides optimal coverage for people with high healthcare needs; and 3) ensuring persons in the pool have access to affordable coverage by offering, for example, the same level of tax credits and subsidies as those in the Marketplace.

Cost of Claims

The cost of health care claims in Iowa spiked post ACA and the spike has persisted. A number of factors are driving the high cost of claims. For example, prescription drug costs, in particular specialty drugs, are driving up the overall cost of healthcare. In addition, the high cost of hospital stays, higher levels of hospital utilization, and increasing advances in technology are putting upward pressure on costs. More transparency and communication around costs and a focus on quality and outcomes would ultimately help bend down the cost curve. by better communicating costs prior to services obtained. Informed consumers of any good or service will ultimately lead to a better performing health care market.

The ACA reformed insurance dramatically, but does little to address other costs. A continued focus on outcomes, transparency, quality, drug pricing, and wellness is critical to bend down the cost of care. The insurance industry can work within the health care system to address these issues, but it cannot be expected to do that alone. The issues with health care extend well beyond insurance and a review of the entire health care economy and marketplace is necessary.

Conclusion

Despite the political controversy surrounding the ACA, we all want the same thing: for people to have access to affordable, quality healthcare. State and federal policy makers need to work together to address the shortcomings of the ACA and work to ensure that state health insurance markets remain vibrant. It is time to work together to make substantive corrections. The states stand ready to assist.

Testimony of Washington State Insurance Commissioner Mike Kreidler

**Before the U.S. Senate Committee on
Homeland Security and Governmental Affairs**

**September 15, 2016
10:00 AM**

Good morning Chairman Johnson, Ranking Member Carper, and members of the committee.

Thank you for the opportunity to testify today about our individual health insurance market under the Affordable Care Act (ACA).

My name is Mike Kreidler, and I am the statewide-elected Insurance Commissioner for the state of Washington, the longest-serving insurance commissioner in the country, and a former member of Congress. I am testifying today on behalf of the people of Washington state.

I've spent most of my career in the health care field – either as a provider, elected policymaker or health administrator, and have worked for years to reform our health care system.

For the last six years, I have been leading efforts to implement the Affordable Care Act in my state. It has not always been easy, but the benefits have been profound.

I remember clearly what our health insurance market looked like before reform.

At the end of 2013, before the Affordable Care Act took effect, almost a million people in our state were uninsured. That is 14 percent of our state's population.

We had more than \$2 billion in uncompensated care costs.

We were fortunate to have very good competition, with 11 health insurers participating in our individual market, but most of the plans did not cover maternity or prescription drugs – two vital services for most families.

It was clear to me then that without significant health reform, our current health care system was not sustainable. Medical costs would continue to rise and more people would become uninsured.

Today, our uninsured rate is down to 7.3 percent – representing a 50 percent drop since the Affordable Care Act took effect, and the lowest rate we've seen since at least 1987.

Our uncompensated care costs are down from \$2.3 billion to \$1.2 billion.

Seventy-eight percent of people enrolled through our state's exchange, Washington Healthplanfinder, receive a subsidy to help pay for their coverage.

People have access to meaningful coverage that provides critical services when and if they need them.

This year, 13 health insurers filed 154 health plans for our 2017 individual market – both inside and outside of our Exchange, with an average requested rate increase of 13.5 percent.

Most of these plans and their rates are still under review, so we will not have a complete picture of our individual market until October.

Now, 13.5 percent is higher than we have seen in the last two years, but it is not unexpected nor is it higher than what we saw before passage of the ACA. Even with our aggressive rate review, double-digit rate requests were common, but so was being denied coverage when you needed it. And you could not find an individual health plan in our state that covered prescription drugs.

In 2014, when our Exchange opened, the insurers set their rates, making their best guess at who would sign up and what medical services they would need. They now have two years of experience, which is still very limited.

They also had to estimate the payments or credits they would either owe or receive from the federal risk adjustment program. Most of our insurers have had to revise their requests based on allotments from this program, announced by the Centers for Medicare and Medicaid Services in June of this year.

No one wants to see their premiums go up. I have been in this job for many years, and I understand the impact any increase has on individuals and families. The Affordable Care Act is doing what it was designed to do – helping people access health care. But if we want to bring premium relief to consumers and stabilize the

markets nationwide – if we are serious about reforming what is wrong with our health care system – we need to look beyond the Affordable Care Act. We need to get everyone covered and we need to do more to bring down the costs of health care.

Our first step must be stopping the skyrocketing costs of prescription drugs. Across the board – for every insurer in our individual market – prescription drug costs was the single biggest driver of medical trend. If we do not bring down drug costs, we will not lower premiums.

Every state should be required to expand Medicaid. Our decision to do so in Washington state has helped 595,000 adults get covered and is the key reason our uninsured rate has dropped to a record low.

We must get rid of non-conforming health plans that dilute the risk pool. If you do not have everyone covered, sharing the risk, you simply cannot bring down costs. States that opted to keep old legacy policies in place when President Obama said if you like your plan you can keep it, understand this firsthand.

The Affordable Care Act is working in Washington state because we took full advantage of the reforms it provided. I believe we will see premiums in our market stabilize as insurers gain more experience. But unless we as a country take on the tough challenges and start talking about how to really slow down the cost of health care and get everyone covered, we will not bring sustainable relief to all consumers.

Thank you.

September 15, 2016

**STATEMENT FROM WILLIAM A. HAZEL, M.D., SECRETARY OF HEALTH AND HUMAN RESOURCES,
COMMONWEALTH OF VIRGINIA**

Virginia has greatly benefited from the passage of the Affordable Care Act (ACA). First and foremost, the number of uninsured people in Virginia has decreased since its passage. Enrollment in the Federal Health Insurance Marketplace is increasing, and while some state markets have seen disruption via the departure of major health plans, Virginia's market remains healthy and ready to offer choice to its consumers. Virginia has benefited from federal flexibility authorized by the ACA to improve care for Medicare and Medicaid enrollees via the Commonwealth Coordinated Care Program. The Commonwealth has also leveraged federal funding to modernize our benefit program eligibility determination system. In addition to these benefits, Virginia also has an opportunity to realize further gains through Medicaid expansion.

In 2010, 1,020,000 or 13.1 percent of Virginians were uninsured. As of 2015, Virginia has seen a 27 percent drop in the number of uninsured Virginians to 746,000, or 9.1 percent of the total population. Health Insurance Marketplace enrollment has increased from 216,000 policies purchased in 2014 to 421,000 policies in 2016. Virginia has attained its highest enrollment to date and ranks 7th highest in the nation.

This decrease in the uninsured rate directly benefits Virginia's state budget. The cost of providing care to the uninsured at hospitals is projected to fall by \$33 million in state fiscal year 2018, largely due to enrollment in the federal marketplace.

The Health Insurance Marketplace in Virginia continues to grow and remains strong. In 2017, ten health insurance carriers will offer plans in the Virginia exchange, including two new carriers: Aetna Health, Inc. and Cigna Health and Life Insurance Company.

Some of the often-overlooked aspects of the ACA are the demonstration projects for reforms that add value to the system.

One of these projects in Virginia is Commonwealth Coordinated Care, a Financial Alignment Demonstration administered through collaboration between the Centers for Medicare and Medicaid Services (CMS) and Virginia's Department of Medical Assistance Services (DMAS). The collaboration to implement CCC was made possible when the ACA established the Medicare Medicaid Coordination Office (MMCO) under CMS. Virginia's Commonwealth Coordinated Care focuses on a person-centered approach for Medicare-Medicaid enrollees and coordinates services across primary, acute, behavioral health, and long-term services and supports. Virginia is one of 13 states participating in the Financial Alignment Demonstration and more than 27,000 Virginians are benefitting from this program.

Virginia has also taken advantage of CMMI funding, a state innovation model planning grant to establish a statewide metrics to align population health and clinical care. We have analyzed data to demonstrate

ways to reduce wasteful medical tests and procedures; we have worked to improve care transitions and hospital readmissions; and are working to prepare physicians for value-based payment methodologies.

Virginia is leveraging a 90/10 federal match from CMS to modernize our eligibility determination system in coordination with the Virginia Department of Social Services (DSS). Virginia implemented the program with the intent of having one system for Medicaid eligibility, TANF, SNAP, and other DSS programs.

States that have expanded Medicaid have realized a much larger reduction in the rates of uninsured than Virginia. Over 400,000 currently uninsured Virginians would benefit from a Medicaid expansion, and closing the coverage gap would provide additional resources in critical need areas such as behavioral health and addiction recovery and treatment services.

"The State of Health Insurance Markets"

Senate Homeland Security and Governmental Affairs Committee

September 15, 2016

Testimony: Christopher F. Koller, President Milbank Memorial Fund

Chairman Johnson and Ranking Member Carper:

Thank you for the chance to submit written testimony for this hearing. The Milbank Memorial Fund is a 110 year old operating foundation that works with state health policy makers to improve population health by connecting them with the best evidence and experience. Prior to assuming leadership of this organization in 2013, I served the state of Rhode Island for eight years as the country's first Health Insurance Commissioner, during the implementation of the Affordable Care Act. Before that I ran the state's largest Medicaid Managed Care health plan, Neighborhood Health Plan of Rhode Island.

I hope these experiences in running and regulating health insurance plans and overseeing a commercial health insurance market are of use to the committee as it does this important work.

The goal of health insurance markets should be to offer a range of reliable, affordable options for consumers. In my experience, health insurance markets need the following elements to attain those goals.

1. **Sufficient market size.** Whether offering individual, small group or large group products, there must be a sufficient number of eligible lives to make it worthwhile for insurers to enter and stay in the market. In smaller state-wide markets, the segmentation of small group and individual risk pools by state officials into separate on-exchange and off exchange markets, while politically attractive, has hindered this goal. The District of Columbia and Vermont are two jurisdictions that have merged their markets and benefit as a result.
2. **A reliable, stable mix of healthy and sick people.** Where healthy people – because of weak mandates, grandfathered benefit plans, poor outreach efforts, or enrollment churning – are allowed to exempt themselves from the risk pool, the market suffers. This has been the case in many individual markets in the country and federal action is needed to correct it.

Similarly, total patient cost sharing (premium, copayments, coinsurance and deductibles) must be limited and indexed to inflation at the federal level if we do not want to see poor, healthy people opt out of the risk pool.

3. **Regional non profit insurers committed to serving their markets.** While national insurers provide important choice options and market competition, regional non profits are the backbone of all non self insured health insurance markets. Whether they are Medicaid health plans, Blue Cross and Blue Shield plans or multi-product regional non profits, by their organization and mission, these plans are more reliable partners for states and communities in making local markets function than national insurers.
4. **Consistent, enforceable rating rules that reflect public priorities for spreading anticipated costs differences due to age, family size, health status, gender and other factors.** Actuaries know which populations will use more health care. It is up to policy makers to figure out who pays. These rules need to be consistent across markets, and hence national. My own opinion is that the ACA got these about right. You should not pay more for health insurance because you are sick – and making prices much cheaper for younger people will pose an unacceptable extra financial burden on older people. These rules must then be vigorously enforced in health plan pricing.
5. **Reliable mechanisms for mitigating adverse selection among insurers.** Even with consistent rating factors, sometimes payers – by chance or effort - will attract populations that are systematically healthier or sicker than others, and a mechanism should be made for sharing these costs. Like similar efforts in Medicare Advantage, the federal program risk adjustment program is necessary but refinement is always needed.
6. **Comprehensive state level rate review.** Some state insurance officials are seeing requests for significant rate increases this year. To evaluate them, they need clear statutory direction that requires them to balance affordability and insurer solvency. With scrutiny, regulators can accomplish four specific ends:
 - a. Assess the validity of the insurers' requests and find the right balance between affordability and insurer solvency. In my role in Rhode Island, I had to find this balance repeatedly – determining when and how much rates requests should be cut.
 - b. Ensure that insurers are not allocating administrative costs to the individual market which should be borne by the large group and self insured markets.
 - c. Educate stakeholders on the importance of a policy focus on underlying rates of trend, rather than merely shifting costs to employees in the form of higher premium sharing and to patients and providers in higher cost sharing.
 - d. Document underlying cost drivers in medical services such as pharmacy, hospital care, physician services and educate the public and policy makers both on the benefits and limits of insurer competition as a way to reduce them and the steps needed to address these trends – like

payment reforms aligned across payers, true system integration and limited networks.

We did all of this work in my tenure in Rhode Island. As a result in recent years the state has had the lowest rate of increase in commercial premiums in New England.

Often state insurance regulators do not have comprehensive rate review authority, and frequently they do not use the tools they have to understand the validity of insurers' requests and take necessary actions. CMS's Center for Consumer Information and Insurance Oversight could address this in part by raising its standard for what constitutes adequate state level rate review.

7. **Small numbers of uninsured because of Medicaid expansion.** Reducing the number of uninsured reduces pressure on commercial payments to hospitals to cross subsidize their compensated care. It makes for a more attractive and stable pool of covered lives in the state, reduces insurance "churn", adds new insurers into Medicaid managed care (and thus potentially commercial markets as well) and keeps healthy lives in the both the Medicaid and commercial risk pools.

Markets that are seeing robust insurer competition and lower rates of year over year premium increase – markets as diverse as California and Rhode Island – possess most of these characteristics. Policy makers at the state and federal level need to promote greater adoption of these characteristics and discourage policies which are not supported by evidence, including:

- weakening of individual mandates
- lowering of minimum benefit comprehensiveness and raised cost sharing levels
- inter-state insurer competition

Creating markets with these characteristics requires actions at the state and federal level, as suggested above. To the extent states have not taken all the steps available to them, they continue to suffer the consequences. As Noam Levey of the Los Angeles Times points out, eight of the nine states where consumer choices on the exchange will be most limited in 2017 have rejected Medicaid expansion.

Finally we should not mistake what is driving the problem of health insurance affordability – it is rising health care costs; the same issue that troubles CMS Actuaries and Medicaid Directors. The most robust commercial insurance competition cannot hide the fact that we in the US spend almost two and half times the international average on health care, as a percent of GDP, and get poorer health outcomes as a result. This is a fundamental challenge for our country – robbing us of more productive investments in education, our infrastructure and the environment – and policy makers must rise to it.

Thank you for your time and interest, and for your service.

September 15, 2016

**SENATE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENT AFFAIRS HEARING ON
“THE STATE OF HEALTH INSURANCE MARKETS”**

**STATEMENT FROM SECRETARY RITA LANDGRAF, DELAWARE DEPARTMENT OF HEALTH AND
SOCIAL SERVICES**

Starting in March 2010 when the Affordable Care Act was signed into law, Delaware has been on the forefront of health care reform. As the lead agency in Delaware, the Department of Health and Social Services (DHSS) has worked to implement its state-federal partnership Health Insurance Marketplace, with coverage beginning Jan. 1, 2014, and the enhanced expansion of Medicaid, with coverage beginning on the same date. Delaware expanded Medicaid up to 100% federal poverty level back in 1996 under then Governor Carper. In addition, DHSS has been a significant partner in designing a plan and applying for a federal Center for Medicare and Medicaid Innovation (CMMI) grant, and implementing the plan to change the way health care is delivered and paid for in our state.

In 2008, Delaware’s insured rate was estimated at 11.2 percent, or about 101,000 individuals. That rate ranked Delaware 33rd among the states. By 2015, our state’s uninsured rate was down to 5.9 percent, leaving 54,000 Delawareans without coverage, according to a U.S. Census Bureau report released just this week. Delaware now has the ninth-lowest uninsured rate in the country.

Delaware adopted a state-federal partnership for its Health Insurance Marketplace, meaning Delaware would retain responsibility for plan management and consumer assistance, while the federal government would be responsible for information technology through HealthCare.gov. In the third year of the Marketplace, 28,256 Delawareans were enrolled for private health insurance plans as of January 2016, with enrollment almost doubling from Year 1 to Year 3. Of the 28,245 enrolled in 2016, 82 percent were eligible for a premium tax credit, averaging about \$328 per month. That brought the average monthly premium after the tax credit down 69 percent to \$150 per month. In Delaware, 70 percent of those enrolled pay \$100 or less in monthly premiums, while 64 percent pay \$75 or less.

To further increase coverage, Gov. Jack Markell decided in July 2013 to expanded eligibility for Medicaid up to 138 percent of the Federal Poverty Level beginning Jan. 1, 2014. Through January 2016, 9,896 Delaware adults were eligible for coverage through the expansion.

Still, Delaware’s health care costs are 25 percent above the national average, with \$8 billion spent annually on health care and 22 percent of the State budget devoted to health care costs. Those expenditures have not resulted in a high rate of positive outcomes. Delaware’s rate for

such diseases as diabetes, obesity and cancer are above the U.S. average, and the health of many Delawareans remains at or below average on many measures.

As a way to embrace a “health” care system instead of a “sick” care system, Delaware also is engaged in the work of health care innovation. Beginning in 2013, more than 100 stakeholders, including those representing hospitals, providers, insurers, educational institutions, patients, and government, came together to develop Delaware’s health innovation plan. Based on that plan, Delaware was awarded a four-year, \$35 million grant from the Centers for Medicare and Medicaid Innovation (CMMI) to transform the way health care is delivered and paid for by using a total investment of \$130 million over four years.

In 2015, the Delaware Center for Health Innovation, a not-for-profit organization, was created to carry out the innovation work. The DCHI Board created six committees: Clinical, Workforce and Education, Payment, HIT, Healthy Neighborhoods, and Patient/Consumer Advisory. Two multi-payer, value-based payment models will be offered statewide: Pay-4-Value and Total Cost of Care. Delaware’s goals by 2018 are to become one of the five healthiest states in the U.S.; to achieve top performance for quality and patient experience; to improve provider experience; and to bring health care spending growth more closely in line with the growth of the economy.

During the course of the Committee’s hearing you will hear about a lot of numbers and trends – and those are important – but that’s not the only thing I think about when I think about the difference the Affordable Care Act is making in Delaware.

I think about people like Janice Baker from Selbyville, Del., one of our first enrollees. Janice couldn’t get coverage before the start of Delaware’s Marketplace because of pre-existing conditions she has. During those first days of enrollment, she stayed on HealthCare.gov for hours to make sure she was signed up.

I think about the Reverend Donald Morton of New Castle, Del., who had been uninsured for years, but whose cancer was caught after he signed up for Marketplace coverage and went to the doctor for a physical. He wonders what might have happened if the ACA had not been become law.

And I think about Felipe Hernandez, a 27-year-old machine operator from Wilmington, Del. Unlike his wife and daughter, Felipe did not have insurance coverage. Relatives told him about the Health Insurance Marketplace and he enrolled for coverage beginning in 2014 and re-enrolled after that. Felipe, who pays a monthly premium of about \$73, said he is now more hopeful about his future. “I’ve gone to the doctor for exams, blood work, and medications to prevent future illness,” he said. “My health has improved a lot. I’m not going to go broke because I get sick.”

In all of these cases -- and thousands more -- Delawareans are connected to health care through the Marketplace and the Medicaid expansion. That was the premise and the promise of the ACA -- that we would connect people to coverage and they would get the care they need to get well or to stay healthy. While we face challenges in terms of the cost of premiums, the size of deductibles and our ability to reach people who remain uninsured, I know because of the Affordable Care Act we have made tremendous progress in building a healthier Delaware.



September 14, 2016

The Honorable Ron Johnson, Chairman
 The Honorable Thomas R. Carper, Ranking Member
 U.S. Senate Committee on Homeland Security and Governmental Affairs
 340 Dirksen Senate Office Building
 Washington, DC, 20510

Dear Chairman Johnson, Ranking Member Carper and Committee Members,

As a part of the deliberations to take place during the September 15th U.S. Senate Committee on Homeland Security and Governmental Affairs hearing on the state of Health Insurance Markets, I would like to take this opportunity to provide some background and discussion points as to how the Affordable Care Act is working in California, and the nation.

The Affordable Care Act created a historic new era of health care that is working for millions of people throughout the nation. At the end of the most recent open enrollment period, the Centers for Medicare and Medicaid Services announced that 20 million people had been covered either through a marketplace plan or through expanded Medicaid. Since opening its doors in California, more than 2.5 million individuals have signed up for health care coverage through Covered California, the state's health benefits Exchange. In concert with expanding its Medicaid program, California was able to make significant gains in reducing its number of uninsured and improve access to care. According to a report issued this week by the U.S. Census Bureau, California cut its uninsured rate by half (a reduction of 8.6%) due to the success of both Covered California and the expansion of Medicaid. Our state's uninsured rate now stands at the lowest level on record.

California is using all of the tools made available by the Affordable Care Act to improve health care quality, lower cost, and provide meaningful choice and best value for consumers. Specifically, Covered California:

- ***Creates a competitive health insurance marketplace by requiring insurance carriers to meet high standards of quality, affordability, and accountability as they compete in the marketplace, and also by negotiating the premiums they can charge.*** For 2015 and 2016, the statewide weighted average increase was 4.2 percent and 4 percent respectively. In 2017, the statewide weighted average increase is 13.2 percent. While this change is higher than previous years, the three year average since Covered California began is 7 percent – lower than the pre-Affordable Care Act trend.

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It should be noted that 2017 is a transitional year for premium rates across the nation. The main factor driving these rate changes is the end of the temporary federal reinsurance program, which was designed to help keep rates down during the first three years of the Affordable Care Act. According to the American Academy of Actuaries, the end of the reinsurance program will cause a one-time increase of 4 to 7 percent to 2017 rates.

Another factor contributing to 2017 being a transitional year in many parts of the country is due to adjustment for mispricing. In the early years, insurance carriers did not have any data on their new consumers and had to base rates on their best estimates. Some carriers got it right, while others saw wide fluctuation in cost. It is important to note that while pricing has NOT been a significant issue in California, it has had an impact across the nation. There are two reasons for this fact: first, many states did not transition their individual markets to one common risk pool in 2014. As a result, carriers had difficulty calculating which consumers would and would not be part of the risk pool. California was one of the dozen states to make the conversion to a single risk pool in 2014. Secondly, in California, Covered California provided independent analysis of the risk mix of those enrolling to assist the carriers in pricing appropriately.

We will likely see further rate stabilization in coming years now that carriers have more data on the costs and health status of consumers, and as states finish their transitions to one common risk pool in 2017 and 2018.

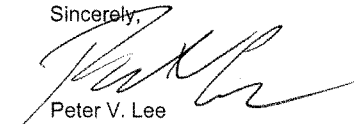
- ***Provides choice and patient-centered benefits to ensure consumers have robust coverage options.*** Consumers have access to standardized health plans specifically designed to reduce the number of services that are subject to a deductible, thus increasing a patient's access to care. Even our most affordable plans in the Bronze tier promote care, allowing consumers to see their doctor or a specialist three times before being subject to the deductible.
- ***Invests in significant marketing, outreach, and enrollment efforts to ensure a healthy risk mix.*** As of May of 2016, Covered California had 1.4 million consumers enrolled in a marketplace plan. In 2015, Covered California provided health plans with compelling data showing that enrollees were healthier and presented less risk, which helped drive down the cost of health premiums and saved an estimated \$100 million in premiums. Over time, Covered California also improved its risk mix by enrolling younger, healthier enrollees. The percentage of consumers between the ages of 18 and 34 who signed up for coverage was 38 percent during our most recent open-enrollment period, up from 29 percent during the first open enrollment.
- ***Helps reduce costs by improving the delivery system.*** Premiums are a reflection of what health care costs and how it is delivered. Covered California works with health insurance carriers to find new and innovative ways to improve quality and lower cost. For example, Covered California is advancing several initiatives that reward quality over quantity with the goal of improving health care delivery.

September 14, 2016
Page 3

The Affordable Care Act is working in California and for Californians, and we have built a sustainable and competitive marketplace. We are seeing lives changed by the security they now have and the quality care they have received. While we have the building blocks in place to create competitive marketplaces for consumers and to promote fundamental changes to the health care system, our job is not done, and there is more work to do. We are committed to helping implement this new era of health care in our state and across the nation.

Thank you for your consideration. Please do not hesitate to contact me if you have any questions or if I can provide additional information.

Sincerely,



Peter V. Lee
Executive Director



September 14th, 2016

The Honorable Thomas Carper
Ranking Member, Senate Committee on
Homeland Security and Governmental Affairs
340 Dirksen Senate Office Building
Washington, DC 20510

Kathleen C Hittner, MD
Health Insurance Commissioner, Rhode
Island Office of the Health Insurance
Commissioner
1511 Pontiac Ave. Bld. 69-1
Cranston, RI 02920

RE: Senate Homeland Security and Governmental Affairs Committee Hearing on the State of Health Insurance Markets.

Dear Mr. Carper,

I appreciate the opportunity to share with you the positive effects that the Patient Protection and Affordable Care Act (ACA) has had in the state of Rhode Island. Rhode Island's health insurance market is made stronger and fairer as a result of the ACA. As Rhode Island's Health Insurance Commissioner, my agency has responsibility for monitoring and enforcing the consumer protection and market reform provisions of the ACA. From a commercial insurance market perspective I highlight three of the most important contributions of the ACA below.

- **Since 2012, Rhode Island's consumers have saved over \$200 million through enhanced rate review.** Rhode Island has received four grants under the Rate Review Grant program. These resources have enabled Rhode Island to build one of the most comprehensive rate review programs in the country. Rhode Island's fully insured market comprises a quarter of a million consumers across the individual, small and large group markets. OHIC's rate review program has saved \$220 million for consumers in these markets since 2012. In the last few years, premiums have been lower and more stable as a result of the work we are doing. For plan year 2017, average premium changes in the individual market will range from a 5.9% decrease to a 5.9% increase, based on issuer. In the small group market, average premium changes in 2017 will range from a decrease of 3.1% to an increase of 3.6%, based on issuer.
- **Since 2012, Rhode Island's uninsured rate has declined from 10.9% to 4.8%.** The ACA has led to significant health insurance coverage expansions in Rhode Island, through more affordable non-group coverage and the Medicaid expansion. Federal dollars have financed key infrastructure, including HealthSource RI, Rhode Island's state-based health insurance exchange, which serves as a national model of success for state-based exchanges. Individual market consumers benefited from more affordable coverage due to \$76 million in tax credits in 2015.
- **The ACA has improved access to preventive health care services for Rhode Island residents** and helped the state establish a consumer assistance program and conduct detailed review of health insurance coverage documents. Consumer protection assumes a more proactive form in Rhode Island as a result of the ACA.

States are a vital partner with the federal government in ensuring that the health care system supports better care, smarter spending, and healthier people. Rhode Island is building on the authority and resources of the Affordable Care Act to support a stable, efficient, and consumer friendly market for health insurance.

Sincerely,

Kathleen C Hittner, MD
Health Insurance Commissioner

Testimony of

Christina Corieri

Before the

Senate Committee on Homeland Security and Governmental Affairs

September 15, 2016

Christina Corieri

Senior Policy Advisor to Arizona Governor Doug Ducey

Phoenix, AZ

September 15, 2016

The Honorable Ron Johnson, Chairman
Senate Committee on Homeland Security and Governmental Affairs
340 Dirksen Senate Office Building
Washington, DC, 20510

The Honorable Thomas R. Carper, Ranking Member
Senate Committee on Homeland Security and Governmental Affairs
340 Dirksen Senate Office Building
Washington, DC, 20510

Dear Chairman Johnson, Ranking Member Carper, Members of the Senate Homeland Security and Governmental Affairs Committee:

As you consider testimony regarding the state of health insurance markets, I would like to submit for your consideration, brief comments on the impact that we have seen in Arizona.

The Patient Protection and Affordable Care Act, commonly referred to as Obamacare, has created an extremely unstable market in Arizona. When the Obamacare marketplaces were first rolled out, President Obama promised that individuals would “find more choices, more competition, and in many cases, lower prices.” Unfortunately for Arizonans, none of those promises have materialized.

In 2013, before the opening of the exchanges, Arizona had 24 insurance companies selling plans on the individual market. In 2017, consumers who shop for plans on the exchange in Arizona will have only one option for their plan. In reality, choosing between a single insurance plan, or being financially penalized by the federal government for not purchasing a plan, is not a true choice and it is certainly not the choice and competition that was promised to consumers by the president. I want to personally commend Senators McCain and Flake for their effort to pass legislation that would at least insulate individuals who have no choice from being financially penalized for the failings of the system.

Unfortunately, it is not just the choice of insurance plans that has decreased as a result of Obamacare. Choice within those plans has also decreased as insurers have narrowed their networks to protect themselves from further losses. And as we all know, when choice decreases, costs increase. Consumers on the exchange in Arizona will see an average increase in 2017 of 49%. While many people who receive subsidies will be insulated from those increases, enrollees who do not receive a subsidy may find that the steep increases are unaffordable. We know for certain that these are not the lower prices that Americans were told they could expect.

Even more concerning for Arizona, there was a time when it appeared that Pinal County would be the first county in the country without a single insurer willing to offer a plan on the exchange. While Blue Cross Blue Shield has recently decided to offer a plan there at a 50% premium increase, it is only a matter of time until another county faces the prospect of being without an insurer on the exchange. The situation that Pinal County faced illustrates that Obamacare is

broken, its promises have failed to materialize, and it is time for Congress to return to the drawing board to fix it.

Sincerely,

Christina Corieri
Senior Policy Advisor to Arizona Governor Doug Ducey

**Post Hearing Questions for the Record
Submitted to the Honorable Mary Taylor
From Senator Joni Ernst**

Question 1:

In your written testimony, you mentioned an HHS study from this August that said more consumers will be able to qualify for federal subsidies as premiums continue to rise. It seems like the suggestion is that it's good thing – get people more subsidies and rate hikes will be less shocking. But if trends continue, what does this mean for the American taxpayer, who is ultimately paying the bill for these subsidies? Is the ACA making anything more affordable as Americans were promised?

Response:

Premiums are going to increase and will continue to increase unless the underlying cost of health care is addressed. The Affordable Care Act (ACA) has often been described as health care reform, but it is really health insurance reform. Because the law is not addressing those contributing factors, health care costs will continue to rise which will result in higher premiums. As the federal government released information on October 24 about national premium increases on the exchanges, the argument on behalf of the consumer was about subsidization. At no point, however, did the administration admit those rising premiums mean higher subsidy costs that every American taxpayer must pay for. As constructed today, the ACA is headed toward financial collapse.

**Post-Hearing Questions for the Record
Submitted to the Honorable Mary Taylor
From Senator Ben Sasse**

Question 1:

How much money has InHealth Mutual repaid the federal government for their solvency and start-up loans thus far?

Response:

Once an insurance company is put into liquidation, Ohio statute determines how funds are disbursed as claims and other financial obligations are processed.

Question 2:

How much do you estimate will be repaid in the future?

Response:

Any funds paid out during the liquidation process are dictated by what state law requires in Ohio.

Question 3:

Is it realistic to assume InHealth Mutual and the 16 other failed Co-Ops will repay any of their loans?

Response:

Because the other Co-Ops are regulated by other states, we would not be able to predict how those processes will work.

Question 4:

How many people were forced to change plans in the middle of the year due to the collapse of InHealth Mutual?

Response:

At the time InHealth Mutual was placed into liquidation, approximately 22,000 Ohioans were enrolled with coverage.

Question 5:

What happened to the out-of-pocket costs that were already paid by these enrollees? Were the amounts already paid credited to a new plan or did they have to start over towards meeting their out-of-pocket maximums and deductibles?

Response:

Unfortunately, consumers enrolled with InHealth Mutual when the company was liquidated were unable to rollover their out-of-pocket maximum and deductible usage as a credit if they moved to a new plan. Those that continued with their InHealth Mutual plan through the remainder of this coverage year would have not experienced any changes in their out-of-pocket maximums or their deductibles until they switched to a new plan.

Question 6:

Do you know how many consumers in Ohio will be left with fewer than two insurers on the exchange next year?

Response:

We know that there will be 20 counties with just one carrier for the 2017 plan year and an additional 27 counties will have just two carriers. Data around consumers impacted by the change in carrier participation is not something the Department of Insurance maintains.

Question 7:

What percentage of Ohio counties will have three or more insurers?

Response:

Of Ohio's 88 counties, 41 counties will have three or more carriers selling federal exchange products during open enrollment for 2017. That represents approximately 47 percent of the state. The other 47 counties – or 53 percent of the state – will have either one or two carriers selling exchange products.

Question 8:

How many issuers have decreased their coverage options from 2016 to 2017?

Response:

All carriers selling on the federal exchange in Ohio have made changes to their plans for 2017. In addition to those changes, four carriers have withdrawn from the market and others have made reductions in their coverage areas.

Question 9:

How many people will be forced out of their current plan?

Response:

The Department of Insurance does not maintain data specific to federal exchange enrollees who will lose their current plan for 2017. The U.S. Department of Health and Human Services would have the most accurate information pertaining to other plan changes.

**Post-Hearing Questions for the Record
Submitted to the Honorable Mary Taylor
From Senator Kelly A. Ayotte**

Question 1:

Lieutenant Governor, your state has had to deal with the consequences of the failure of one of the co-op health insurance companies established and funded by the Affordable Care Act (ACA). As you note in your written testimony, the Ohio Department of Insurance had to take control of Coordinated Health Mutual in May 2016.

As of September, 17 of the 23 co-ops established by the ACA have failed. Recently, one of the 6 remaining co-ops—Community Health Options—announced that it would stop selling plans on the New Hampshire partnership exchange, deciding to only offer plans in neighboring Maine. As a result of this decision, more than 11,000 of my constituents will have to find a new plan with a new insurance carrier during the upcoming open enrollment period.

- A) Community Health Options, the co-op that recently announced it would not be offering plans on the New Hampshire partnership exchange, insured approximately 11,000 people in my home state last year. Taking into account your experience in Ohio with the failure of Coordinated Health Mutual, what impact will the withdrawal of an insurer have on individuals and families who were insured under that carrier? For example, is there a chance they may not be able to see their preferred health care provider or be treated in their preferred hospital?

Response:

Any time an insurance carrier exits a market, it has an impact – whether its auto, homeowners or health insurance. When a health insurance carrier exits, all of its consumers shift to other carriers, changing the risk pools that those remaining carriers

will cover moving forward. That could have an impact on the premium those remaining carriers charge for the coverage offered. It could also mean a change in the provider network. The fewer carriers selling a product in a specific area, the more likely it is for some providers to be left out of the network. All of these changes impact consumers and may impact cost and access.

- B) What specific challenges did the Ohio Department of Insurance face in taking over the operations of Coordinated Health Mutual? For example, was the state required to pay any liabilities that the co-op had outstanding to providers in its network?

Response:

In Ohio, the state does not pay when an insurance company is placed into liquidation. A combination of the state's guarantee fund as well as the company's remaining assets are used to pay claims and other financial responsibilities. That process in Ohio is dictated by state statute.

- C) What was the average consumer experience of someone who lost their health insurance due to the failure of Coordinated Health Mutual?

Response:

It is hard for the Department of Insurance to capture the average experience of any one consumer impacted by the liquidation of Coordinated Health Mutual. However, any time an insurance carrier is put into liquidation, every consumer is impacted with inconvenience, some may be impacted with additional costs, and others may struggle to find a plan that provides the same level of coverage. Certainly, what happened with Coordinated Health Mutual and with all other Co-Ops that were operating around the country resulted in a negative impact to the markets where those entities offered coverage.

- D) What were some of the challenges facing Coordinated Health Mutual that eventually led to its failure? For example, did the co-op set actuarially sound rates when it first entered the market?

Response:

Health insurance is a complicated market and companies selling on the exchanges across the country have well established footprints with significant expertise in that space. Coordinated Health Mutual faced some of the same challenges all insurance carriers are facing today but without the advantage of the resources and years of experience that other insurers had prior to the ACA.

- E) Both Ohio and New Hampshire have areas that are rural. Does selecting a health insurance provider and plan when there are fewer options available pose any additional obstacles for residents living in rural areas?

Response:

Lack of choice can be difficult for any consumer whether in a rural or urban environment. Certainly, however, there tend to be less providers in less populated areas so fewer options can be challenging for Ohioans living in more rural parts of the state.

Question 2:

Lieutenant Governor, in your written testimony you note that in Ohio next year 19 counties will have a single insurer offering plans on the ACA exchange while 28 counties will only have two insurers offering plans. You make the point in your testimony that this is not the competition that was previously envisioned by supporters of the health care law.

In my home state of New Hampshire, during the first open enrollment period, only one insurer in the entire state offered plans on the exchange. As a result, Granite Staters were faced with an extremely narrow network that limited their ability to see their own doctor or visit the hospital of their choice.

- A) Please provide additional details regarding how the ACA has impacted competition in the health insurance marketplace.

Response:

Implementation of the ACA has resulted in significant change in Ohio's health insurance market. Prior to the ACA, there were more than 60 companies selling health insurance products in Ohio. Now there are fewer than 40. Specifically, as it relates to the federal exchange in Ohio, 17 companies sold products in that market this year while only 11 are selling coverage for 2017. With less participation on the federal exchange, fewer options are available to consumers. As a result, access to care and the cost of coverage could be impacted.

- B) What impact does a lack of competition have on the costs of health insurance?

Response:

Because Ohio has always had a competitive insurance market when it comes to all types of insurance – health, life, auto, homeowners – the price of the products has been lower than the national average. Prior to the ACA, Ohio's health insurance premiums were competitive and over the years our auto and homeowners insurance have consistently been among the lowest in the country. But as carriers leave the health insurance market in Ohio, we are concerned premiums will increase even more leaving consumers with less choice and higher health insurance costs.

- C) How can a lack of competition among health insurance companies impact the type and quality of health care an individual may receive? For example, could an individual face barriers when it comes to the physicians she may want to see or the hospital in which she may wish to receive care?

Response:

Good competition leads to better outcomes. That seems true in all aspects of life and it is certainly true when it comes to free markets. When competition is eroded and potentially even eliminated, the incentive to excel isn't as strong. Certainly, as carriers continue to leave the federal exchange in Ohio, there is the potential for consumers to see an impact on networks and the availability of care when it comes to their doctor or their hospital.

Question 3:

Across the country, states continue to see rising premiums and deductibles. As of September, the average rate increase requested by insurers in the individual market was 23 percent.

- A) Are you concerned that a tipping point may be reached where the cost of health insurance becomes so unaffordable that relatively healthy individuals may see little benefit in paying for a plan that often has a high deductible along with high premiums?

Response:

I think we're already at that tipping point. Simply look across the country and you will see state exchanges struggling with an older, sicker population than was initially anticipated. As a result, enrollment numbers are significantly less than was projected. In order for the system to work, younger, healthier consumers have to buy the products. But what we're seeing is the exact opposite. That group is not interested in buying mandate heavy coverage that is too expensive for the care they anticipate they need in their 20s and 30s. As premiums continue to increase and competition is further reduced, there will be even less incentive for healthier consumers to purchase an exchange plan.

- B) If the answer to the question above is yes, how soon do you believe this point may be reached?

Response:

As I indicated above, I believe we are already at the tipping point. My concern moving forward is how do carriers react after this enrollment season? What happens if enrollment for 2017 is weak again and the risk pools continue to be more expensive than is sustainable? If carriers continue to leave the exchange market, there won't be anyone left to sell products.

- C) What would be the implications on the health insurance marketplace should premiums and deductibles continue to rise in the absence of an adequate risk pool?

Response:

If current trends are not reversed in the exchanges, we could see a death spiral in which prices continue to rise so much that only the sick stay because they need the coverage making the risk pool impossible to cover with premiums collected. I am concerned based on current trends we are rapidly heading in that direction especially in states where only one carrier is selling products.

**Post-Hearing Questions for the Record
Submitted to the Honorable Mary Taylor
From Senator Claire McCaskill**

Question 1:

In your testimony you described issues communicating with the Department of Health and Human Services and the vagueness of guidelines and regulations. Can you please describe in detail instances of unclear directives, the difficulties you had in communicating with HHS officials, and the method in which this information was disseminated or not disseminated to your agency.

Response:

Communicating with HHS over the past six years has been difficult and often inconsistent. Guidance from the agency when it comes to rules is often put off until the last minute and then provides little detail when specificity is required or is too prescriptive when flexibility is in the best interest of state regulators.

Question 2:

You claim that the cost of implementing the ACA outweighs the benefits that consumers receive. Have you done any cost comparison of unpaid medical care and medical debt before and after the implementation of the exchanges? If so, what were the results of that?

Response:

As a regulatory agency, the Department of Insurance does not conduct such studies, therefore we do not have such data. A recent study from the Ohio Hospital Association, however, shows that from 2013 to 2014 in Ohio, bad debt increased from \$1.04 billion to \$1.23 billion (an increase of \$190 million) indicating the ACA may not be helping reduce the bad debt consumers are incurring when it comes to health insurance.

Question 3:

In an effort to understand and discover best practices for efficacy, please explain how your agency "requires insurers to update their information in a more timely fashion" and what the safeguards are to "protect the consumer from making decisions based on outdated network directories."

Response:

Recently, the Department of Insurance adopted new network transparency rules as it relates to provider networks in Ohio. Through these rules, standards have been put in place to ensure provider networks are updated through the carrier on a regular basis, allowing consumers to better understand whether their doctor is in network or not.

Question 4:

In your state, what have been the biggest gaps in insurance, care provided, and access to treatment for those afflicted with opioid addiction? What issue or best practices are you seeing in terms of provider availability, access to care, insurance coverage and affordability of specialized care?

Response:

Even with the implementation of the ACA, there are still gaps in coverage. There are still hundreds of thousands of Ohioans living without health insurance. Many are going without insurance because they cannot afford the coverage that is available especially as premiums continue to increase. We also know many Ohioans enrolled in ACA compliant exchange products often face large out of pocket costs and high deductibles. Those costs on top of whatever premium they may pay make it difficult to get care they need. As the market continues to change and carriers reduce their coverage areas or withdraw completely, access to care is impacted. While more Ohioans have health insurance today than did in 2010, there are still certainly challenges that must be addressed.

Question 5:

Prescription drug pricing is mentioned in all 4 testimonies. We've seen that when the price of pharmaceuticals goes up, the cost is often times directly passed to the consumer. In your experience with the Ohio health exchanges, how has prescription drug pricing affected consumers especially those looking to purchase a plan on the exchanges?

Response:

The Department of Insurance does not have any regulatory authority over prescription drug prices in Ohio. Anecdotally, however, it appears that drug prices are continuing to rapidly increase and drive up the cost of health care. This is an issue for all consumers, including those purchasing coverage through the federal exchange, which is why more emphasis needs to be placed on dealing with the underlying costs of health care.

**Post-Hearing Questions for the Record
Submitted to the Honorable Mary Taylor
From Senator Jon Tester**

Question 1:

Would the risk corridor program have better worked to stabilize insurance markets if Congress had not prohibited funding for it?

Response:

Changes to any programs implemented by the ACA have an impact on how the law operates. However, the risk corridor, risk adjustment and reinsurance programs are not the only drivers of the law's failures. The way the ACA was designed, it was always going to be unsustainable and problematic. In order to address the underlying costs of health care while also encouraging the younger and healthier consumers to enroll in coverage, significant changes need to be made at the federal level in order to provide states with more flexibility and fewer Washington mandates.

Question 2:

Besides the changes that came from health care reform, what factors do you see contributing to the growth of health care costs, and what actions do you recommend to address these issues?

Response:

Health care reform cannot be exclusively focused on insurance, which is what the ACA did. Instead, you have to look at the entire system. In Ohio, we have been focusing on quality and not quantity of care, while also driving better outcomes for patients through innovation, collaboration and efficiencies. These are areas where an impact can be made on the cost of coverage which impacts insurance.

Question 3:

What steps do you recommend be taken to encourage more healthy people to invest in insurance coverage, or otherwise improve the risk pool in individual markets?

Response:

When costs are addressed and when more competition is permitted in the market instead of being suffocated out through government intervention, that is what will bring younger, healthier consumers back to the market and make the risk pools more manageable and less costly.

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**Post Hearing Questions for the Record
Submitted to Mr. J.P. Wieske
From Senator Joni Ernst
“The State of Health Insurance Markets”**

September 15, 2016

1. In your written testimony, you mentioned that Wisconsin already had many consumer protection reforms in place pre-ACA. What drove those choices in your state and could there have been a way to incentivize more states to do that, without a top-down mandate?

Wisconsin, like other states, is best suited to make decisions related to our health insurance market. No one market across the country is alike, from their consumer needs, state geography (rural vs. urban areas), provider accessibility, insurer competition, etc. While state laws have varied, there were many states that had a large number of consumer protections in place. Pre-ACA, the state legislative process was allowed to work to ensure requirements governing the health insurance market met market needs and demands. Historically, state consumers, providers and insurers actively participated in that process to achieve goals for the health insurance market. Now, the “one size fits all” federal regulations add another layer of complexity that confines the state’s ability to react to its market.

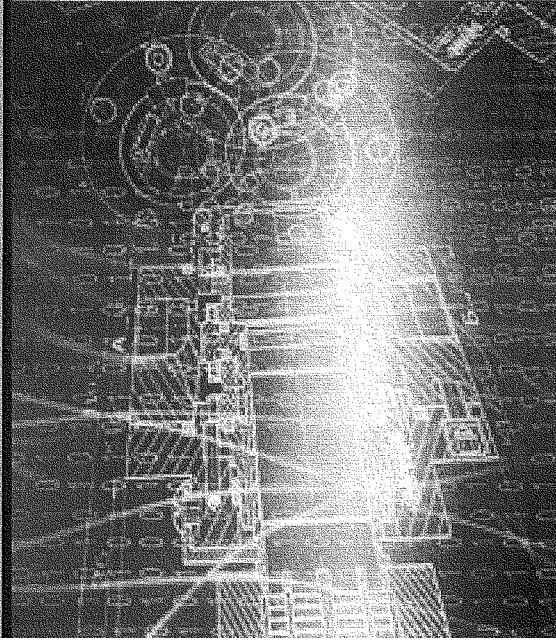
In short, Wisconsin wasn’t unique. Many states made the same decisions and passed many of the same reforms. Most states had laws in place that provided some level of guaranteed coverage for individuals with medical conditions. All states had portability laws on the books to ensure individuals leaving coverage could get guaranteed issue coverage. The true issue was affordability. The current one-size fits all approach has only made it less affordable.

2. You also discussed HHS’ automatic reenrollment of consumers into a new plan when canceled exchange plans are no longer available. How is this information communicated to consumers? HHS has a communication plan. Please see the attached power point.

If consumers find out the plan they were automatically assigned isn’t working for them because of cost or narrow networks, do they have any recourse? It is my understanding that a consumer’s opportunity to choose a plan, other than the one HHS assigns, is limited to the open enrollment period. If a consumer makes their first premium payment during open enrollment for the plan that HHS assigns, HHS would argue the consumer is agreeing to the plan. There is not a Special Enrollment Period opportunity for consumers who are auto enrolled into a plan and later find that it does not meet their needs.



Marketplace Consumer Communications: Discontinued Plans



*Center for Consumer
Information and
Insurance Oversight
(CCIIO)*

September 19, 2016

Pre-Open Enrollment

- Consumers receive official MOEN and issuer discontinuation notices in October
- Additional outreach to consumers with discontinued plans (2-3 touches):
 - Acknowledging plan discontinuation,
 - Encouraging them to shop for the plan that meets their needs and budget during OE
 - Reinforcing the availability of financial help via the Marketplace
- Consumers in discontinued plans are eligible for a loss of MEC SEP for 12/31. Communications will still focus consumers on active plan selection by Dec 15 to help ensure timely enrollment for January 1 (i.e. welcome kits and cards are received so consumers can use coverage beginning 1/1)

November 1 – 15

- Consumers with discontinued plans will receive targeted communication and additional touches totaling a minimum of (+7 touches).
- As a secondary message, communication will inform them that the Marketplace will match them with an alternate plan later in the month to ensure they do not have a gap in coverage.
- If consumers login to HealthCare.gov during this time, they will see in their plan results their “Current or Alternate Plan” listed at the top. The description of the alternate plan will be similar to: *“If your current plan isn’t available for 2017, an alternate plan is displayed for you to consider.”*

November 16 – 21

- Outreach (3+ touches), including a Marketplace notice, notifying discontinued consumers that the Marketplace has:
 - Matched them to an alternate plan with [Insurance company name] (*where possible*).
 - Consumers may receive communication from that insurance company in the coming weeks including a welcome kit and a bill. They should keep this communication until they've selected their 2017 plan.
 - Consumers are under no obligation to start their coverage with this new insurance company.
 - Consumers should actively shop for a plan by December 15.

November 21 – December 15

- Outreach encouraging discontinued consumers to shop and actively renew their coverage by the December 15 deadline.
- Communication ramps in proximity to the deadline (20+ touches).
- The Marketplace will send enrollment transactions for alternate plans the week of November 21

December 16 – 31

- Outreach reminding consumers that the Marketplace matched them with an alternate plan to protect them from a gap in coverage (5+ touches).
- They must pay their first bill with the new insurance company they were matched with or they will not have coverage on January 1st.
- Consumers are under no obligation to pay bill if they want to select a different plan. Consumers should attest to the loss of MEC on 12/31 and they will still be able to select a new plan for coverage starting January 1st.
- Don't wait until the end or it may take longer for you to receive your new bill and insurance card and you may miss out on time to use your benefits in January.

**Post-Hearing Questions for the Record
Submitted to Mr. J.P. Wieske
From Senator Ben Sasse
“The State of Health Insurance Markets”**

September 15, 2016

1. Is Wisconsin’s CO-OP, the Common Ground Healthcare Cooperative, financially stable? Common Ground does not currently have any restrictions on writing business. OCI will not approve an insurer in a financially hazardous condition to write new coverage.
2. Did the Wisconsin CO-OP lose money in 2014 or 2015? Is it losing money this year? If so, how much? In general, insurer financial information is proprietary. However on their annual statements which are public, Common Ground reported statutory net losses of \$28,249,077 in 2015 and \$36,544,668 in 2014.
3. Do you think it will be able to offer coverage in 2017? Yes
4. Has the CO-OP requested a premium increase for 2017 coverage? If so, for how much? Yes, the average increase in the individual market is 27.69% in 2017.
5. Does the CO-OP plan to expand or retract coverage options in 2017? In the individual market, the CO-OP dropped one gold plan and added two new silver plans.
6. Do you expect consumer choice of insurers on the exchange to decrease in your state in 2017 compared to 2016? Yes, consumer choice will decrease. As publicly announced, United and Humana exited the Wisconsin individual insurance market. There are additional insurers that offered plans on Exchange in 2016 who are not planning to offer in 2017. Also, there are insurers who will continue to offer on Exchange in 2017 but who have reduced their service areas.
7. How does the county-level insurer choice in the exchanges compare to choices available in the individual markets in your states prior to the ACA? Has it increased or decreased? When looking at the number of insurers offering coverage on Exchange vs. pre-ACA off Exchange in each county, there are generally fewer options available on Exchange. However, the off Exchange market still exists in Wisconsin and consumers can choose an insurer offering coverage off Exchange only (and those insurers offering on Exchange must offer their plans off Exchange). Those consumers who rely on federal subsidies have less choice as they are limited to insurers offering on Exchange.

The number of insurers offering on Exchange varies county by county so some consumers have more choice than others. Wisconsin’s competitive health insurance market has historically led to consumer choice among several national or local insurers. The ACA continues to challenge Wisconsin’s market, as seen with the recent market exits.

**Post-Hearing Questions for the Record
Submitted to Mr. J.P. Wiese
From Senator Claire McCaskill**

“The State of Health Insurance Markets”

September 15, 2016

In your testimony you described issues your agency had communicating with the Department of Health and Human Services particularly regarding change of regulations without significant notice. Can you please describe in detail instances of regulation change without notice, the difficulties you had in communicating with HHS officials, and the method in which this information was disseminated to your agency. Unfortunately, there are too many instances to detail including ignoring President Obama’s Executive Order 13563 requiring regulations to allow at least a 60-day comment period, an unwillingness to communicate in writing, providing inconsistent responses and using informal means of communications like FAQ’s to offer substantive guidance.

The violation of Executive Order 13563 is particularly frustrating because HHS proposed regulations often contain significant changes to current processes, procedures, programs, etc. The timeframes allotted for public comment are too often limited to timeframes that do not allow stakeholders to digest what is proposed and submit thoughtful responses that not only point to concerns, but also include alternatives to address those concerns. The most egregious was the comment period for the 2017 Notice of Benefit and Payment Parameters. CMS only allowed a 30 day comment period from the date of public posting. With the Thanksgiving holiday, the comment period was only 19 days from the date it was posted in the *Federal Register* on December 2nd. And, this included major policy changes like federal network adequacy standards, standardized plans, auto re-enrollment. Comments on the Annual Letters to Insurers (which include crucial deadlines that impact both Exchange and off-Exchange plans) have also been limited to 30 days.

A 30-day comment period was also provided for such complicated regulations as Essential Health Benefits; Actuarial Value; and Market Regulations.

As a result of circumventing the public comment period, HHS has issued regulations that are not clear. When HHS is asked for clarification, the responses – if provided at all – are inconsistent depending on which arm of the agency responds. Too often, the agency has refused to respond in writing to specific questions. In some cases, after enough confusion is apparent in the market, HHS will issue an FAQ to clarify its intent which also may not be consistent with earlier messaging. This adds to confusion and requires insurers and regulators to change course. Regulation through informal means including the use of FAQ’s is troubling. Oral guidance and FAQ’s are not on equal footing with statutes and regulations as enforcement tools.

Additionally, you also claim that there were instances of “cherry picking which insurers will get additional business” thus interfering with a free market. Please describe in detail the instances in which this occurred, the companies involved, and provide any relevant information that indicates there was favoritism shown. Regulator interference by picking winners and losers is troubling. It is our belief that consumers should be allowed to pick their own plans without interference. My reference to “cherry picking” relates to the HHS auto re-enrollment process, whereby HHS is auto enrolling individuals into new plans offered by an insurer the consumer did not choose. This is planned for consumers who have coverage in 2016 with an insurer that either does not intend to offer plans on the Exchange in 2017 or will not be available in the consumer’s service area for 2017.

In a free market, consumers are not pre-assigned a plan. They do their own shopping and choose the plan with the insurer that best suits their needs. Insurers compete with each other to get business. HHS is deciding which insurers in an area receive the business through its auto re-enrollment process. Because some insurers are getting thousands of lives enrolled with them, automatically, by HHS, the market has been put at risk. Auto re-enrolling over 37,000 people into plans they did not choose will ultimately have a negative financial impact on our insurers. More importantly, this will add significantly to consumer confusion.

Prescription drug pricing is mentioned in all 4 testimonies. We’ve seen that when the price of pharmaceuticals goes up, the cost is often times directly passed to the consumer. In your experience with the Wisconsin health exchanges, how has prescription drug pricing affected consumers especially those looking to purchase a plan on the exchanges? The increasing cost of prescription drugs has had a number of important impacts on pricing in a number of ways. It is certainly a component of higher premium costs. Some insurers have made changes to their plan designs to reflect higher drug costs. It is also important to note that rules crafted by HHS have also limited the ability of insurers to react to drug pricing issues. A number of the rules may have actually increased drug spending costs without providing consumer value.

**Post-Hearing Questions for the Record
Submitted to J.P. Wiese
From Senator Jon Tester
Homeland Security and Governmental Affairs Hearing: "The State of Health Insurance
Markets"
September 15, 2016**

1. Would the risk corridor program have better worked to stabilize insurance markets if Congress had not prohibited funding for it? No. It was flawed from HHS's fundamental misunderstanding of the health insurance market, and their decision to federalize all of the programs that allowed risk transfer.
2. Besides the changes that came from health care reform, what factors do you see contributing to the growth of health care costs, and what actions do you recommend to address these issues? First, it is important to understand the difference between health care costs and health insurance premiums. Health care reform has significantly impacted the cost of health insurance premiums, and made it more difficult to control health care costs that drive health insurance premiums. Health care reform/the ACA/ Obamacare has incentivized adverse selection in health insurance. In dictating who must be covered and the level of coverage that must be provided, without appropriate safeguards to ensure the amount of risk insurers take on is balanced, the Affordable Care Act has resulted in increased health insurance premiums. Increased costs makes health insurance less accessible to those who need it and impacts the cost of medical care when providers are left with unpaid charges. Additionally, the charges providers seek for care is driven by geography, advances in technology, varying degrees of managed care, hospital and practitioner relationships, etc.

There are a number of ways to address increasing health care costs that drive up health insurance premiums. There has been some work on value based plan design to ensure the delivery of effective medical care. Consumer-driven solutions, which provide consumers with the tools to make better medical decisions, provide some promise. Insurers and medical providers have been working collaboratively in some cases to find better outcomes. However, the over regulation of the health insurance market has consistently shown poor results.

3. What steps do you recommend be taken to encourage more healthy people to invest in insurance coverage, or otherwise improve the risk pool in individual markets? Like with other products available for sale, individuals should retain the choice to purchase health insurance or not, based on their needs. As the primary regulators of health insurance in their states, State Insurance Departments, along with state legislatures, consumers, providers and health insurers should determine the rules for offering health insurance

coverage in their states, without the overlay of “one size fits all” federal regulations that are not responsive to state specific market dynamics.

**Post-Hearing Questions for the Record
Submitted to Mr. Nick Gerhart
From Senator Kelly A. Ayotte**

**“The State of Health Insurance Markets”
September 15, 2016**

1. Commissioner Gerhart, you have a unique understanding of what occurs after a health insurance company ceases operations, as Iowa was one of two states in which CoOpportunity Health—the first failed co-op health insurer—offered plans.

Last year, your Department announced that it would be seeking the liquidation of CoOpportunity Health, one of the 23 health insurance co-ops established with taxpayer dollars under the Affordable Care Act (ACA). This announcement was made shortly after regulators in your state took over operations of the co-op.

As of September, 17 of the 23 co-ops established by the ACA have failed. Recently, one of the 6 remaining co-ops—Community Health Options—announced that it would stop selling plans on the New Hampshire partnership exchange, deciding to only offer plans in neighboring Maine. As a result of this decision, more than 11,000 of my constituents will have to find a new plan with a new insurance carrier during the upcoming open enrollment period.

- A) What are some of the unique and especially difficult challenges posed by a health insurance company failing in the middle of the plan year—like CoOpportunity Health did? Understanding you may not be as familiar with plans operating in other states, in your professional opinion, do you believe it is possible that another co-op could fail in the middle of a plan year?

Response: The remaining Marketplace insurers and the consumers of the failed company are both impacted by a “middle of the plan year” failure. The remaining insurers are faced with absorbing potentially thousands of members during the special enrollment period. Smaller, regional carriers may not have the network capacity to absorb the increased numbers.

Also, the consumers of the failed company are forced to find another company that may not have the same providers, potentially resulting in non-continuity of treatment. Additionally, and as we saw in Iowa, the new insurer is not required to honor the consumer’s existing cost sharing payments that were made towards the consumer’s out-of-pocket maximum (i.e. deductible.) So, consumers had to ‘start over’ in payment towards their deductibles and out-of-pocket maximums.

Given the experiences of the co-ops, I do believe it is possible for another co-op to fail in the middle of the plan year, particularly because the Risk

Adjustment charges become known in the middle of the year while the Risk Corridor payments are not known until later in the year.

- B) While Community Health Options announced prior to the start of open enrollment that it wouldn't be offering plans on the New Hampshire partnership exchange, this decision will still require more than 11,000 Granite Staters to select a new health insurance carrier next year. What impact will this have on individuals and families who were customers of Community Health Options? For example, is there a chance they may not be able to see their preferred health care provider or be treated in their preferred hospital?

Response: Yes, there is a chance consumers may not be able to see their preferred health care providers or may not be treated in their preferred hospitals. This may occur if the providers in the insurers' networks are different.

- C) Both Iowa and New Hampshire are rural states. Does selecting a health insurance provider and plan when there are fewer options available pose any additional obstacles for residents living in rural areas?

Response: Yes, consumers in rural areas may face additional obstacles if their new insurer has a different provider network. As discussed earlier, if the insurers' networks do not have the same providers, consumers may have to seek treatment from different providers, potentially resulting in non-continuity of care.

Additionally, people in rural areas often need to travel long distances to be able to see their providers. A change in providers may result in longer travel times for consumers.

- D) What was the average consumer experience of someone who lost their health insurance due to the failure of CoOpportunity Health? Were accommodations made to assist individuals and families with finding a new health insurance plan? Was your Department made aware of situations where individuals or families who lost their health insurance mid-plan year were unable to access or afford health care, or had to delay office visits or necessary medical procedures due to a lack of insurance?

Response: It is important to know that although CoOpportunity was placed into receivership in December 2014, coverage was available through the Iowa and Nebraska Guaranty Associations until August 31, 2015. Consumers had ample time to change coverage and the Iowa Insurance Division (IID) sent numerous communications to both consumers and providers during this

timeframe to address the questions received. In general, the communications sent to consumers explained that CoOpportunity would no longer provide coverage in Iowa and urged them to immediately enroll with another carrier. Provider communications explained the rehabilitation and liquidation processes and ensured providers that they would continue to receive payment for services to CoOpportunity consumers. Examples of these communications may be viewed in the following links:

<http://www.iid.state.ia.us/node/10074703>

<http://www.iid.state.ia.us/node/10074702>

<http://www.iid.state.ia.us/node/9999268>

<http://www.iid.state.ia.us/node/10163569>

<http://www.iid.state.ia.us/node/9961281>

<http://www.iid.state.ia.us/node/9961282>

<http://www.iid.state.ia.us/node/9961280>

<http://www.iid.state.ia.us/node/9953683>

<http://www.iid.state.ia.us/node/9923296>

<http://www.iid.state.ia.us/node/9923293>

<http://www.iid.state.ia.us/node/9885312>

Additionally, because CoOpportunity was ordered into rehabilitation in late December, its consumers had the option to change coverage during the 2015 open enrollment period that ran through February 15, 2015. Consumers also had two special enrollment periods (SEP). The first SEP was from March 1 through April 30, 2015 and the second SEP was from July 1 through August 31, 2015.

- E) What were some of the challenges facing CoOpportunity Health that eventually led to its failure? For example, did the co-op set actuarially sound rates when it first entered the market?

Response: CoOpportunity faced multiple challenges that eventually led to its failure including but not limited to:

1. When CoOpportunity Health entered the market its rates were not adequate. Among other things it appears that its medical management

was not sufficient, its provider network was too costly and its prescription drug formulary/tiers structure was inappropriate.

2. The federal decision to allow for the continuation of the Transitional policies kept healthy individuals out of the Marketplace. Premiums from healthy individuals with Grand-mothered policies were not available to help off-set the costs of enrollees who had high health costs.
 3. As a non-profit company, CoOpportunity was prohibited from raising funds in the manner of a commercial carrier. Also, the timing of federal Reinsurance payments and the inability to access or collateralize the Reinsurance or Risk Corridor amounts owed meant CoOpportunity had significant unliquid assets that could not be utilized.
2. In your written testimony you note that the number of Iowans purchasing health insurance in the individual market has actually decreased since the enactment of the Affordable Care Act.

- A) What factors are leading to fewer consumers in Iowa purchasing plans on the individual market?

Response: Several factors include but are not limited to the following:

1. The weakness of the individual mandate.
2. The high cost of the plans for the younger, healthier population.
Factors that contributed to these costs include, the 3:1 age band rating requirement and incorrect assumptions about the average age of consumers (The average age of Iowa's population is much higher than the assumed age of 35).
3. Iowa's expansion of Medicaid.

- B) Are the individuals who are no longer purchasing plans on the individual market insured through a different type of plan or program, or are these individuals now uninsured?

Response: Although more Iowans are covered today, we have to guess as to why fewer individual are purchasing coverage. It is unclear as to whether these persons have become eligible for Medicare or Medicaid, become eligible for employer-sponsored insurance, or been able, as young adults, to stay on their parents' insurance. It is also possible that some may have obtained coverage through Health Care Sharing Ministries (HCSM). Since the ACA was passed, enrollment numbers in HCSMs have increased nationally from approximately 140,000 to approximately 600,000. HCSMs may fulfil the individual mandate requirement for individuals, but are not insurance and are not regulated by state divisions of insurance.

3. In your written testimony, you note that insurance rates in Iowa have increased every year since 2014.

A) Are you concerned that a tipping point may be reached where the cost of health insurance becomes so unaffordable that relatively healthy individuals may see little benefit in paying for a plan that often has a high deductible along with high premiums?

Response: Yes.

B) If the answer to the question above is yes, how soon do you believe this point may be reached?

Response: We are entering this point in calendar year 2017. A significant number of Iowans may be exempt from the individual mandate due to their insurance being 'unaffordable' per the ACA requirements that premiums not exceed 8.13 percent of the consumer's annual household income. *(8.13 is the 'unaffordable percentage for 2016; this number is adjusted annually.)*

C) What would be the implications on the health insurance marketplace should premiums and deductibles continue to rise in the absence of an adequate risk pool?

Response: No private carrier will offer individual health coverage, on or off the Marketplace. The only persons with health insurance will be those with employer-sponsored insurance. Small businesses will likely not be able to continue offering health insurance coverage.

**Post-Hearing Questions for the Record
Submitted to Mr. Nick Gerhart
From Senator Ben Sasse**

“The State of Health Insurance Markets”

September 15, 2016

1. How much money has CoOpportunity repaid the federal government for their solvency and start-up loans thus far?

Response: The federal government set-off and sent to the U.S. Treasury approximately \$15.2 million to repay CoOpportunity’s \$14.7 million start-up loan and associated interest. The \$15.2 million was withheld from CoOpportunity by the federal government for 2014 amounts due CoOpportunity for federal Reinsurance, Risk Adjustment and Risk Corridor programs. CoOpportunity is in litigation with HHS regarding the legality of that setoff, applicable law and proper accounting of amounts due CoOpportunity from the federal government.

CoOpportunity is owed \$155 million for Risk Corridor for 2014-2015, an amount which far exceeds amounts CoOpportunity owes the federal government (CoOpportunity’s solvency loans are surplus notes and are expressly subordinated by the federal government, to be repaid only when approved by the Commissioner and all other creditors have been paid).

2. How much do you estimate will be repaid in the future?

Response: It is difficult to determine at this time how much can be repaid the federal government given the uncertainty over Risk Corridor payments. If the federal government pays \$155 million owed CoOpportunity for 2014-2015, CoOpportunity may be able to repay all of its other creditors, the start-up loan and approximately \$70 million of its \$132 million of solvency loan. The federal government has already withheld over \$30 million from CoOpportunity to set-off amounts owed by CoOpportunity on Risk Adjustment and for its Start Up loan.

3. Is it realistic to assume CoOpportunity and the 16 other failed CO-OPs will repay any of their loans?

Response: It is more than realistic that a substantial portion of their loans can be repaid if the CoOps are paid the Risk Corridor amounts they are owed. In CoOpportunity’s situation, this would mean repayment of all of its start-up loan and over 50% of its solvency loan.

4. How many people were forced to change plans in the middle of the year due to the collapse of CoOpportunity?

Response: About 110,000 people had to get health coverage from different carriers as a result of CoOpportunity's insolvency.

5. For CoOpportunity, how many enrollees were from Iowa and how many were from Nebraska?

Response: Of the 109,960 people enrolled with CoOpportunity as of January 1, 2015, 27,068 were enrolled in Iowa and 82,892 were enrolled in Nebraska.

6. What happened to the out-of-pocket costs that were already paid by these enrollees? Were the amounts already paid credited to a new plan or did they have to start over towards meeting their out-of-pocket maximums and deductibles?

Response: Information on whether any credit for out-of-pocket costs was provided by other carriers would need to come from those carriers. Coventry did not provide such credits to CoOpportunity consumers.

7. Do you expect consumer choice of insurer on the exchange to decrease in Iowa in 2017 compared to 2016?

Response: In 2016, Iowa has 2 state-wide carriers, United HealthCare and Medica. In 2017, Medica will be the only state-wide carrier. Even with the additional of two new, regional carriers, we have fewer choices of carriers at the county level because carriers are choosing to offer regional plans with narrow networks.

8. How does the county-level insurer choice in the exchanges compare to choices available in the individual markets in Iowa prior to the ACA? Has it increased or decreased?

Response: Choices prior to the ACA focused on the availability or accessibility of provider networks as opposed to the current discussion which is focused on the availability or operations of carriers in certain counties. The county-level insurer choice has decreased since the ACA was implemented.

**Post-Hearing Questions for the Record
Submitted to Mr. Nick Gerhart
From Senator Claire McCaskill**

“The State of Health Insurance Markets”

September 15, 2016

In your testimony, you claimed that expanding Medicaid was a key component of creating more affordable plans. Can you please explain how the expansion of Medicaid would open the doors for those in ‘the gap’ between the poverty line requirements for standard Medicaid eligibility and being unable to afford private insurance plan, especially those on the exchanges?

Response: I respectfully disagree with your statement that I “claimed that expanding Medicaid was a key component of creating more affordable plans.” Expanding Medicaid was a key component of increasing the insured rate in Iowa, but it did not create more affordable plans. Regarding your question about ‘the gap’ in poverty line requirements, the Medicaid expansion provides coverage to adults ages 19 through 64 who have income at or below 133 percent of the Federal Poverty Level (FPL). Iowa implemented the Medicaid expansion on January 1, 2014. Prior to this time, Iowa’s Medicaid program did not provide coverage to the expansion population. Implementing the Medicaid expansion provided coverage to approximately 150,000 Iowans, many of whom did not previously have coverage. At the end of March 2016, approximately 107,000 Medicaid expansion members had income at or below 100 percent of the FPL and therefore, would not qualify for the ACA’s Advanced Premium Tax Credits (APTCs) or Cost Sharing Reductions (CSRs) available for Marketplace plans.

Prescription drug pricing is mentioned in all 4 testimonies. We’ve seen that when the price of pharmaceuticals goes up, the cost is often times directly passed to the consumer. In your experience with the Iowa health exchanges, how has prescription drug pricing affected consumers especially those looking to purchase a plan on the exchanges?

Response: In Iowa, the prescription drug component of plan pricing is significant, and has been growing at a quicker rate relative to other components of pricing. Drug tiering has also led to adverse selection of those carriers that offer the more expensive prescriptions at lower tiers.

**Post-Hearing Questions for the Record
Submitted to Nick Gerhart
From Senator Jon Tester**

**Homeland Security and Governmental Affairs Hearing: “The State of Health Insurance Markets”
September 15, 2016**

1. Would the risk corridor program have better worked to stabilize insurance markets if Congress had not prohibited funding for it?

Response: Yes, if the program met the expectations of the carriers’ pricing models, it may have worked as envisioned. However, because most carriers sustained losses, the payout was just over 12 cents on the dollar for calendar year 2014.

Regardless, the risk corridor program led to a moral hazard in pricing because carriers had the ‘false confidence’ that even if they mispriced their rates, there was a federal back-stop. I believe this is a failed business model and, as stated in my testimony, the federal government should focus on allowing the reinsurance program to continue in a manner that protects individual state interests.

2. Besides the changes that came from health care reform, what factors do you see contributing to the growth of health care costs, and what actions do you recommend to address these issues?

Response: The rising costs of prescription drugs and inpatient, outpatient and professional services have contributed to the growth of health care costs. Use of accountable care organizations in the commercial market may help address this growth. As I testified, one of Iowa’s commercial carriers has seen early success with ACOs.

3. What steps do you recommend be taken to encourage more healthy people to invest in insurance coverage, or otherwise improve the risk pool in individual markets?

Response: As detailed in my testimony, I believe Federal legislative changes should be considered to allow the reinsurance program to continue in a manner that protects individual state interests. Federal flexibility with the single risk pool requirements through 1332 waivers and addressing the increasing costs of health care are also reforms necessary to ensure the continued viability of the individual markets. Currently, due to the single risk pool, individual mandate, and other ACA requirements, the federal government set up a system that has created adverse selection within the risk pool. Healthy people are being asked to subsidize the costs of adverse selection within the risk pool. As prices climb, many may choose to pursue exemptions such as Health Care Sharing Ministries (in order to avoid the individual mandate penalty); choose to pay the

individual mandate penalty while having no health insurance coverage; or choose to go without any health coverage and not have to pay the individual mandate penalty (if the cost is deemed 'unaffordable' per the ACA requirements).

**Post-Hearing Questions for the Record
Submitted to Hon. Mike Kreidler
From Senator Ben Sasse**

“The State of Health Insurance Markets”

September 15, 2016

- 1. Do you expect consumer choice of insurer on the exchange to decrease in your state in 2017 compared to 2016?**

In 2015, 12 insurers applied and were approved to sell 136 individual health plans for 2016 in our exchange, Washington Healthplanfinder. This year, nine insurers applied and were approved to sell 98 health plans inside our exchange in 2017.


- 2. How does the county-level insurer choice in the exchanges compare to choices available in the individual markets in your states prior to the ACA? Has it increased or decreased?**

Prior to the Affordable Care Act, Washington state had nine health insurers in its individual market. Today, it has 13 insurers. Nine of them are selling inside our exchange, Washington Healthplanfinder. Here is a link to a [chart of the health insurers and plans available by county](#) inside and outside of our exchange for 2017.

In 2013, before the Affordable Care Act, three insurers –Lifewise, Time, and ODS Health Plan, Inc. - sold statewide in our individual health insurance market. Attached is a PDF of the 2013 guide to the Washington state individual market that includes the insurers and their plans by county.

Shopping for an

Individual Health Plan

 Washington State
Office of the
Insurance Commissioner
www.insurance.wa.gov

Mike Kreidler
Insurance Commissioner

Buying an individual health plan

An individual health plan is health insurance you buy directly from an insurance company for yourself or for family members. Some individual health plans may not be sold where you live. Before you select a plan, look at the chart on page 3 to see what plans are offered in your county.

Once you know which plans are offered in your county, be sure to compare the benefits and costs.

Rates

How much you'll pay a month for a plan depends on several factors including:

- Your age
- Whether or not you smoke
- The size of your family (how many people you want to cover)
- The deductible amount (what you have to pay out of pocket before the plans starts to pay)

Generally, the higher the deductible you select, the less you'll pay per month.

High-deductible/catastrophic health plans

Most of these health plans are NOT portable. This means if you select another plan in the future, you may have to wait up to **9 months** for coverage of a pre-existing condition after your insurance takes effect.

2013 deductibles: \$1,970 or more for one person
 \$3,940 or more for two people

Before you make a final decision on costs and benefits, call the plan directly to get the most current benefit information and rates. Company contact information is available on the next page.

All requests to change rates are public. Go to www.insurance.wa.gov to:

- View proposed rate increases
- Sign up to get notified by email when rates increase
- See how we review rates
- Post comments on a pending rate request
- Read frequently asked questions

Shopping for individual health plans

Contact the companies

For more information about specific individual health plans, contact the insurance company using the toll-free phone number or visit their website.

Asuris Northwest Health 1-866-704-2708 www.asuris.com	ODS Health Plan, Inc. 1-866-939-0368 www.odscompanies.com
Group Health Cooperative 1-800-358-8815 www.ghc.org	Premiera Blue Cross 1-800-PLAN-ONE (800-752-6663) www.premiera.com
Group Health Options 1-800-358-8815 www.ghc.org	Regence BlueCross BlueShield of Oregon 1-888-734-3623 www.regence.com
Kaiser Foundation Health Plan of the Northwest 1-800-914-5519 www.kaiserpermanente.org	Regence BlueShield of Washington 1-888-734-3623 www.regence.com
LifeWise Health Plan of Washington 1-800-592-6804 www.lifewisewa.com	Time Insurance Company (Assurant Health) 1-800-394-4296 www.assuranthealth.com

To see which plans are available in your county, please review the chart on the following page.

Individual health plans by county

Asuris Northwest Health	Group Health Cooperative	Group Health Options	Kaiser Foundation Health Plan of the Northwest	LifeWise Health Plan Washington	ODS Health Plan, Inc.	Premiera Blue Cross	Regence BlueCross/ BlueShield Oregon	Regence BlueShield Washington	Time Insurance Company	
X				X	X	X			X	Adams
X				X	X	X			X	Asotin
X	X	X		X	X	X			X	Benton
X				X	X	X			X	Chelan
				X	X	X		X	X	Clallam
	X	X	X	X	X	X	X	X	X	Clark
			X	X	X	X		X	X	Columbia
				X	X	X		X	X	Cowlitz
X				X	X	X			X	Douglas
X				X	X	X			X	Ferry
X	X	X		X	X	X			X	Franklin
X				X	X	X			X	Garfield
X				X	X	X			X	Grant
	X*	X*		X	X	X		X	X	Grays Harbor
	X	X		X	X	X		X	X	Island
				X	X	X		X	X	Jefferson
	X	X		X	X	X		X	X	King
	X	X		X	X	X		X	X	Kitsap
X	X	X		X	X	X			X	Kittitas
				X	X	X		X	X	Klickitat
	X	X	X	X	X	X		X	X	Lewis
X				X	X	X			X	Lincoln
	X	X		X	X	X		X	X	Mason
X				X	X	X			X	Okanogan
				X	X	X		X	X	Pacific
X				X	X	X			X	Pend Oreille
	X	X		X	X	X		X	X	Pierce
	X	X		X	X	X		X	X	San Juan
	X	X		X	X	X		X	X	Skagit
			X	X	X	X		X	X	Skamania
	X	X		X	X	X		X	X	Snohomish
X	X	X		X	X	X			X	Spokane
X				X	X	X			X	Stevens
	X	X		X	X	X		X	X	Thurston
			X	X	X	X		X	X	Wahkiakum
	X	X		X	X	X		X	X	Walla Walla
	X	X		X	X	X		X	X	Whatcom
X	X	X		X	X	X			X	Whitman
	X	X		X	X	X		X	X	Yakima

* Coverage service area varies by zip code.

Asuris Northwest Health
Monthly Rates for Individual Plans
Rate Effective Date 10/1/2012
Page One

Plan Name	Smoker/Non-Smoker	Child	Age Band 0-24	Age Band 25-29	Age Band 30-34	Age Band 35-39	Age Band 40-44	Age Band 45-49	Age Band 50-54	Age Band 55-59	Age Band 60+
Asuris Emerge Core Plan, \$2,500 Deductible	Non-Smoker	\$122	\$122	\$140	\$163	\$192	\$226	\$273	\$325	\$382	\$447
	Smoker	\$122	\$140	\$161	\$187	\$221	\$260	\$314	\$374	\$439	\$514
Asuris Emerge Core Plan, \$5,000 Deductible	Non-Smoker	\$100	\$100	\$115	\$134	\$158	\$186	\$225	\$268	\$314	\$368
	Smoker	\$100	\$115	\$133	\$154	\$182	\$214	\$259	\$308	\$361	\$423
Asuris Emerge Core Plan, \$7,500 Deductible	Non-Smoker	\$87	\$87	\$100	\$116	\$137	\$161	\$195	\$232	\$273	\$320
	Smoker	\$87	\$100	\$115	\$134	\$158	\$186	\$225	\$267	\$314	\$368
Asuris Emerge Core Plan, \$10,000 Deductible	Non-Smoker	\$78	\$78	\$90	\$104	\$123	\$145	\$176	\$209	\$245	\$287
	Smoker	\$78	\$90	\$103	\$120	\$142	\$167	\$202	\$240	\$282	\$330

Asuris Northwest Health

Monthly Rates for Individual Plans

Rate Effective Date 10/1/2012

Page Two

Plan Name	Smoker/Non-Smoker	Child	Age Band 0-24	Age Band 25-29	Age Band 30-34	Age Band 35-39	Age Band 40-44	Age Band 45-49	Age Band 50-54	Age Band 55-59	Age Band 60+
Asuris Emerge Plus Plan, \$1,000 Deductible	Non-Smoker	\$265	\$265	\$304	\$354	\$417	\$491	\$594	\$707	\$830	\$972
	Smoker	\$265	\$305	\$350	\$407	\$480	\$565	\$683	\$813	\$954	\$1,118
Asuris Emerge Plus Plan, \$5,000 Deductible	Non-Smoker	\$167	\$167	\$191	\$222	\$262	\$309	\$373	\$444	\$522	\$611
	Smoker	\$167	\$192	\$220	\$256	\$302	\$355	\$430	\$511	\$600	\$703
Asuris Emerge Plus Plan, \$7,500 Deductible	Non-Smoker	\$151	\$151	\$173	\$201	\$238	\$280	\$338	\$403	\$472	\$553
	Smoker	\$151	\$174	\$199	\$231	\$273	\$321	\$389	\$463	\$543	\$636

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Asuris Northwest Health

Monthly Rates for Individual Plans

Rate Effective Date 10/1/2012

Page Three

Plan Name	Smoker/Non-Smoker	Child	Age Band 0-24	Age Band 25-29	Age Band 30-34	Age Band 35-39	Age Band 40-44	Age Band 45-49	Age Band 50-54	Age Band 55-59	Age Band 60+
Asuris Emerge HSA 80 Plan, \$2,000/\$4,000 Deductible	Non-Smoker	\$159	\$159	\$182	\$212	\$250	\$294	\$356	\$423	\$497	\$582
	Smoker	\$159	\$182	\$209	\$243	\$287	\$338	\$409	\$487	\$571	\$669
Asuris Emerge HSA 80 Plan, \$3,500/\$7,000 Deductible	Non-Smoker	\$127	\$127	\$146	\$169	\$200	\$235	\$285	\$339	\$397	\$466
	Smoker	\$127	\$146	\$168	\$195	\$230	\$270	\$327	\$389	\$457	\$535

Group Health Cooperative

Monthly Rates for Individual Market Plans
Effective 7/1/2012

Plan Name	Area	Smoker/Non-Smoker	Child	Age Band 0-24	Age Band 25-29	Age Band 30-34	Age Band 35-39	Age Band 40-44	Age Band 45-49	Age Band 50-54	Age Band 55-59	Age Band 60-64	65+ (N)	(A&B)	(A)	(B)
Welcome \$1000 Deductible Plan 12	Western	Smoker	\$172	\$342	\$370	\$429	\$401	\$416	\$478	\$589	\$701	\$905	\$905	\$572	\$861	\$861
		Non-Smoker	\$172	\$283	\$306	\$355	\$334	\$349	\$399	\$492	\$587	\$754	\$754	\$480	\$717	\$717
	Central and Eastern	Smoker	\$176	\$349	\$406	\$440	\$408	\$428	\$489	\$602	\$718	\$927	\$927	\$628	\$879	\$879
		Non-Smoker	\$176	\$291	\$339	\$368	\$342	\$355	\$406	\$503	\$598	\$775	\$775	\$522	\$732	\$732
Welcome \$2000 Deductible Plan 12	Western	Smoker	\$83	\$122	\$134	\$148	\$162	\$198	\$233	\$282	\$345	\$438	\$438	\$369	\$418	\$418
		Non-Smoker	\$83	\$102	\$114	\$124	\$135	\$166	\$193	\$234	\$286	\$367	\$367	\$309	\$349	\$349
	Central and Eastern	Smoker	\$85	\$125	\$136	\$150	\$167	\$203	\$237	\$286	\$353	\$447	\$447	\$369	\$426	\$426
		Non-Smoker	\$85	\$103	\$116	\$126	\$137	\$168	\$199	\$240	\$294	\$374	\$374	\$309	\$355	\$355
Welcome \$3500 Deductible Plan 12	Western	Smoker	\$70	\$103	\$111	\$122	\$136	\$167	\$196	\$237	\$290	\$367	\$367	\$367	\$367	\$367
		Non-Smoker	\$70	\$87	\$95	\$103	\$115	\$138	\$164	\$196	\$243	\$306	\$306	\$306	\$306	\$306
	Central and Eastern	Smoker	\$71	\$105	\$116	\$126	\$138	\$171	\$201	\$241	\$298	\$376	\$376	\$376	\$376	\$376
		Non-Smoker	\$71	\$88	\$96	\$105	\$117	\$141	\$168	\$201	\$247	\$314	\$314	\$314	\$314	\$314
HSA \$2000 Individual / \$4000 Family Catastrophic Deductible Plan 12	Western	Smoker	\$86	\$124	\$135	\$149	\$166	\$201	\$236	\$284	\$349	\$442	\$442	\$442	\$442	\$442
		Non-Smoker	\$86	\$104	\$115	\$124	\$137	\$168	\$197	\$236	\$292	\$368	\$368	\$368	\$368	\$368
	Central and Eastern	Smoker	\$89	\$127	\$137	\$151	\$170	\$207	\$241	\$288	\$357	\$451	\$451	\$451	\$451	\$451
		Non-Smoker	\$89	\$106	\$117	\$126	\$140	\$170	\$203	\$242	\$299	\$374	\$374	\$374	\$374	\$374

65+(N): 65 and over, not eligible for Medicare
(A&B): Plan members enrolled in Medicare Parts A and B
(A): Plan members enrolled in Medicare Part A
(B): Plan members enrolled in Medicare Part B

Group Health Options, Inc.

Monthly Rates for Individual Market Plans
Effective 7/1/2012

Plan Name	Area	Smoker/Non-Smoker	Age Band										
			Child	0-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Balance 1750 Plan - 12 \$1750 Deductible	Western	Smoker	\$172	\$356	\$432	\$449	\$417	\$436	\$497	\$615	\$735	\$946	\$946
		Non-Smoker	\$172	\$297	\$361	\$377	\$348	\$364	\$416	\$512	\$611	\$789	\$789
	Eastern	Smoker	\$175	\$364	\$442	\$462	\$428	\$445	\$510	\$630	\$752	\$966	\$966
		Non-Smoker	\$175	\$303	\$369	\$383	\$356	\$372	\$423	\$525	\$625	\$810	\$810
Balance 2500 Plan - 12 \$2500 Deductible	Western	Smoker	\$95	\$145	\$159	\$173	\$191	\$235	\$276	\$329	\$404	\$511	\$511
		Non-Smoker	\$95	\$120	\$131	\$147	\$161	\$195	\$230	\$276	\$337	\$427	\$427
	Eastern	Smoker	\$97	\$148	\$162	\$177	\$196	\$239	\$281	\$337	\$413	\$527	\$527
		Non-Smoker	\$97	\$122	\$135	\$148	\$163	\$197	\$237	\$281	\$343	\$439	\$439
Balance 5000 Plan - 12 \$5000 Deductible	Western	Smoker	\$78	\$116	\$128	\$142	\$155	\$189	\$222	\$269	\$326	\$414	\$414
		Non-Smoker	\$78	\$100	\$107	\$116	\$129	\$157	\$184	\$222	\$273	\$346	\$346
	Eastern	Smoker	\$80	\$118	\$130	\$143	\$159	\$191	\$229	\$272	\$333	\$426	\$426
		Non-Smoker	\$80	\$101	\$109	\$120	\$132	\$160	\$189	\$229	\$280	\$355	\$355
HSA \$2750 Individual/ \$5500 Family Catastrophic Plan - 12	Western	Smoker	\$92	\$138	\$151	\$165	\$182	\$221	\$262	\$314	\$386	\$488	\$488
		Non-Smoker	\$92	\$115	\$125	\$138	\$152	\$184	\$219	\$262	\$323	\$408	\$408
	Eastern	Smoker	\$94	\$140	\$153	\$168	\$188	\$226	\$268	\$320	\$394	\$499	\$499
		Non-Smoker	\$94	\$116	\$131	\$140	\$157	\$189	\$224	\$269	\$329	\$417	\$417

Kaiser Foundation Health Plan of the Northwest
KP Individuals and Families Plans - Open Plans
New Plans Open to New Enrollees on or after January 1, 2011
Clark County - Non-Smoker Rates
Effective January 1, 2013 Through December 31, 2013
 Enrolled after 12/31/2010

Subscriber Tier	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+
KP 1000/25/Rx - Form RWDEFG10000113, RWRXGU0113, RWWVH0113									
Child/Subscriber Only	\$207	\$245	\$272	\$312	\$386	\$457	\$573	\$666	\$776
Subscriber + Spouse	\$414	\$490	\$544	\$628	\$772	\$914	\$1,140	\$1,332	\$1,552
Subscriber + Child	\$414	\$452	\$479	\$519	\$593	\$664	\$780	\$873	\$983
Subscriber + Children	\$642	\$763	\$790	\$830	\$904	\$975	\$1,091	\$1,184	\$1,294
Subscriber, Spouse, Child	\$621	\$697	\$751	\$831	\$979	\$1,121	\$1,353	\$1,519	\$1,759
Subscriber, Spouse, Children	\$849	\$1,008	\$1,062	\$1,142	\$1,260	\$1,432	\$1,664	\$1,850	\$2,070
KP 1500/20/Rx - Form RWDEDS15000113, RWRXGU0113									
Child/Subscriber Only	\$185	\$218	\$243	\$279	\$344	\$408	\$512	\$594	\$693
Subscriber + Spouse	\$370	\$436	\$486	\$558	\$688	\$816	\$1,024	\$1,188	\$1,386
Subscriber + Child	\$370	\$403	\$428	\$464	\$529	\$593	\$697	\$779	\$878
Subscriber + Children	\$574	\$681	\$706	\$742	\$807	\$871	\$975	\$1,057	\$1,156
Subscriber, Spouse, Child	\$555	\$621	\$671	\$743	\$873	\$1,001	\$1,209	\$1,373	\$1,571
Subscriber, Spouse, Children	\$759	\$899	\$949	\$1,021	\$1,151	\$1,279	\$1,487	\$1,651	\$1,849
KP 2500/20/Rx - Form RWDEDS25000113, RWRXGU0113									
Child/Subscriber Only	\$172	\$203	\$225	\$259	\$320	\$379	\$475	\$552	\$644
Subscriber + Spouse	\$344	\$406	\$450	\$518	\$640	\$758	\$950	\$1,104	\$1,288
Subscriber + Child	\$344	\$375	\$397	\$431	\$492	\$551	\$647	\$724	\$816
Subscriber + Children	\$533	\$633	\$655	\$689	\$750	\$809	\$905	\$982	\$1,074
Subscriber, Spouse, Child	\$516	\$578	\$622	\$690	\$812	\$930	\$1,122	\$1,276	\$1,480
Subscriber, Spouse, Children	\$705	\$836	\$880	\$948	\$1,070	\$1,188	\$1,380	\$1,534	\$1,718
KP 3500/20/Rx - Form RWDEDS35000113, RWRXGU0113									
Child/Subscriber Only	\$165	\$194	\$216	\$248	\$307	\$363	\$456	\$529	\$617
Subscriber + Spouse	\$330	\$388	\$432	\$496	\$614	\$726	\$912	\$1,058	\$1,234
Subscriber + Child	\$330	\$359	\$381	\$413	\$472	\$528	\$621	\$694	\$782
Subscriber + Children	\$512	\$607	\$629	\$661	\$720	\$776	\$869	\$942	\$1,030
Subscriber, Spouse, Child	\$495	\$553	\$597	\$661	\$779	\$891	\$1,077	\$1,223	\$1,399
Subscriber, Spouse, Children	\$677	\$801	\$845	\$909	\$1,027	\$1,139	\$1,325	\$1,471	\$1,647
KP 5000/20/Rx - Form RWDEDS50000113, RWRXGU0113									
Child/Subscriber Only	\$149	\$177	\$196	\$225	\$278	\$330	\$413	\$481	\$558
Subscriber + Spouse	\$298	\$354	\$392	\$450	\$556	\$660	\$826	\$962	\$1,116
Subscriber + Child	\$298	\$326	\$345	\$374	\$427	\$479	\$562	\$630	\$707
Subscriber + Children	\$462	\$550	\$569	\$598	\$651	\$703	\$786	\$854	\$931
Subscriber, Spouse, Child	\$447	\$503	\$541	\$599	\$705	\$809	\$975	\$1,111	\$1,265
Subscriber, Spouse, Children	\$611	\$727	\$765	\$823	\$929	\$1,033	\$1,199	\$1,335	\$1,489
KP 7500/20/Rx - Form RWDEDS75000113, RWRXGU0113									
Child/Subscriber Only	\$136	\$161	\$179	\$205	\$254	\$300	\$377	\$438	\$510
Subscriber + Spouse	\$272	\$322	\$358	\$410	\$508	\$600	\$754	\$876	\$1,020
Subscriber + Child	\$272	\$297	\$315	\$341	\$390	\$436	\$513	\$574	\$646
Subscriber + Children	\$422	\$501	\$519	\$545	\$594	\$640	\$717	\$778	\$850
Subscriber, Spouse, Child	\$408	\$458	\$494	\$546	\$644	\$736	\$890	\$1,012	\$1,156
Subscriber, Spouse, Children	\$558	\$662	\$698	\$750	\$848	\$940	\$1,094	\$1,216	\$1,360
KP 1500/35/NM - Form BWDEDB15000113									
Child/Subscriber Only	\$119	\$141	\$175	\$240	\$323	\$357	\$421	\$434	\$446
Subscriber + Spouse	\$238	\$282	\$330	\$480	\$646	\$714	\$842	\$868	\$892
Subscriber + Child	\$238	\$260	\$294	\$339	\$442	\$476	\$540	\$553	\$565
Subscriber + Children	\$369	\$439	\$473	\$538	\$621	\$655	\$719	\$732	\$744
Subscriber, Spouse, Child	\$357	\$401	\$469	\$599	\$765	\$833	\$961	\$987	\$1,011
Subscriber, Spouse, Children	\$488	\$580	\$648	\$778	\$944	\$1,012	\$1,140	\$1,166	\$1,190
KP 3500/35/NM - Form BWDEDB35000113									
Child/Subscriber Only	\$115	\$136	\$169	\$231	\$312	\$345	\$406	\$419	\$431
Subscriber + Spouse	\$230	\$272	\$338	\$462	\$624	\$690	\$812	\$838	\$862
Subscriber + Child	\$230	\$251	\$284	\$346	\$427	\$460	\$521	\$534	\$546
Subscriber + Children	\$357	\$424	\$457	\$519	\$600	\$633	\$694	\$707	\$719
Subscriber, Spouse, Child	\$345	\$387	\$453	\$577	\$739	\$805	\$927	\$953	\$977
Subscriber, Spouse, Children	\$473	\$560	\$626	\$750	\$912	\$978	\$1,100	\$1,126	\$1,150
KP 5000/35/NM - Form BWDEDB50000113									
Child/Subscriber Only	\$106	\$125	\$155	\$213	\$286	\$317	\$373	\$385	\$397
Subscriber + Spouse	\$212	\$250	\$310	\$426	\$572	\$634	\$746	\$770	\$794
Subscriber + Child	\$212	\$231	\$261	\$319	\$392	\$423	\$479	\$491	\$503
Subscriber + Children	\$329	\$390	\$420	\$478	\$551	\$582	\$638	\$650	\$662
Subscriber, Spouse, Child	\$318	\$356	\$416	\$532	\$678	\$740	\$852	\$876	\$900
Subscriber, Spouse, Children	\$435	\$515	\$575	\$691	\$837	\$899	\$1,011	\$1,035	\$1,059
KP 7500/35/NM - Form BWDEDB75000113									
Child/Subscriber Only	\$98	\$115	\$143	\$196	\$264	\$292	\$344	\$356	\$366
Subscriber + Spouse	\$196	\$230	\$286	\$392	\$528	\$584	\$688	\$712	\$732
Subscriber + Child	\$196	\$213	\$241	\$294	\$362	\$390	\$442	\$454	\$464
Subscriber + Children	\$304	\$360	\$388	\$441	\$509	\$537	\$589	\$601	\$611
Subscriber, Spouse, Child	\$294	\$328	\$384	\$499	\$620	\$682	\$786	\$810	\$830
Subscriber, Spouse, Children	\$402	\$475	\$531	\$637	\$773	\$829	\$933	\$957	\$977

Kaiser Foundation Health Plan of the Northwest
KP Individuals and Families Plans - Open Plans
New Plans Open to New Enrollees on or after January 1, 2011
Clark County - Smoker Rates
Effective January 1, 2013 Through December 31, 2013
Enrolled after 12/31/2010

Subscriber Tier	Subscriber Age							
	<15	15-24	25-34	35-44	45-54	55-64	65-74	65+
KP 1000/25/Rx - Form BWDEDS10000113, RWRXGL0113, RWWH0113								
Child/Subscriber Only	\$253	\$309	\$333	\$383	\$472	\$559	\$702	\$815
Subscriber + Spouse	\$506	\$600	\$666	\$766	\$944	\$1,118	\$1,404	\$1,630
Subscriber + Child	\$506	\$551	\$586	\$636	\$725	\$812	\$955	\$1,068
Subscriber + Children	\$784	\$923	\$966	\$1,016	\$1,105	\$1,192	\$1,335	\$1,448
Subscriber, Spouse, Child	\$759	\$853	\$919	\$1,019	\$1,197	\$1,371	\$1,657	\$1,883
Subscriber, Spouse, Children	\$1,037	\$1,233	\$1,299	\$1,399	\$1,577	\$1,751	\$2,037	\$2,263
KP 1500/30/Rx - Form BWDEDS15000113, RWRXGL0113								
Child/Subscriber Only	\$226	\$267	\$296	\$341	\$421	\$498	\$625	\$726
Subscriber + Spouse	\$452	\$534	\$592	\$682	\$842	\$996	\$1,250	\$1,452
Subscriber + Child	\$452	\$493	\$522	\$567	\$647	\$724	\$851	\$952
Subscriber + Children	\$701	\$832	\$861	\$906	\$986	\$1,063	\$1,190	\$1,291
Subscriber, Spouse, Child	\$678	\$760	\$818	\$908	\$1,068	\$1,232	\$1,476	\$1,678
Subscriber, Spouse, Children	\$927	\$1,099	\$1,157	\$1,247	\$1,407	\$1,561	\$1,815	\$2,017
KP 2500/30/Rx - Form BWDEDS25000113, RWRXGL0113								
Child/Subscriber Only	\$209	\$247	\$275	\$316	\$390	\$462	\$579	\$673
Subscriber + Spouse	\$418	\$494	\$550	\$632	\$780	\$924	\$1,158	\$1,346
Subscriber + Child	\$418	\$456	\$484	\$525	\$599	\$671	\$788	\$892
Subscriber + Children	\$648	\$770	\$798	\$839	\$913	\$985	\$1,106	\$1,206
Subscriber, Spouse, Child	\$627	\$703	\$759	\$841	\$989	\$1,133	\$1,367	\$1,555
Subscriber, Spouse, Children	\$857	\$1,017	\$1,073	\$1,155	\$1,303	\$1,447	\$1,681	\$1,869
KP 3500/30/Rx - Form BWDEDS35000113, RWRXGL0113								
Child/Subscriber Only	\$200	\$237	\$263	\$303	\$374	\$442	\$555	\$645
Subscriber + Spouse	\$400	\$474	\$526	\$606	\$748	\$884	\$1,110	\$1,290
Subscriber + Child	\$400	\$437	\$463	\$503	\$574	\$642	\$755	\$845
Subscriber + Children	\$620	\$737	\$763	\$803	\$874	\$942	\$1,055	\$1,145
Subscriber, Spouse, Child	\$600	\$674	\$726	\$806	\$948	\$1,084	\$1,310	\$1,490
Subscriber, Spouse, Children	\$820	\$974	\$1,026	\$1,106	\$1,248	\$1,384	\$1,610	\$1,790
KP 5000/30/Rx - Form BWDEDS50000113, RWRXGL0113								
Child/Subscriber Only	\$182	\$214	\$238	\$274	\$338	\$400	\$502	\$584
Subscriber + Spouse	\$364	\$428	\$476	\$548	\$676	\$800	\$1,004	\$1,168
Subscriber + Child	\$364	\$396	\$420	\$456	\$520	\$582	\$684	\$766
Subscriber + Children	\$564	\$669	\$693	\$729	\$793	\$855	\$957	\$1,039
Subscriber, Spouse, Child	\$546	\$610	\$658	\$730	\$858	\$982	\$1,186	\$1,350
Subscriber, Spouse, Children	\$746	\$883	\$931	\$1,003	\$1,131	\$1,255	\$1,459	\$1,623
KP 7500/30/Rx - Form BWDEDS75000113, RWRXGL0113								
Child/Subscriber Only	\$145	\$195	\$216	\$249	\$307	\$364	\$456	\$530
Subscriber + Spouse	\$330	\$390	\$432	\$498	\$614	\$728	\$912	\$1,060
Subscriber + Child	\$330	\$360	\$381	\$414	\$472	\$529	\$621	\$693
Subscriber + Children	\$512	\$608	\$629	\$662	\$720	\$777	\$869	\$943
Subscriber, Spouse, Child	\$495	\$555	\$597	\$663	\$779	\$893	\$1,077	\$1,225
Subscriber, Spouse, Children	\$677	\$803	\$845	\$911	\$1,027	\$1,141	\$1,325	\$1,473
KP 1500/35/NM - Form BWDEDS15000113								
Child/Subscriber Only	\$145	\$171	\$212	\$291	\$392	\$433	\$510	\$527
Subscriber + Spouse	\$290	\$342	\$424	\$582	\$784	\$866	\$1,020	\$1,086
Subscriber + Child	\$290	\$316	\$357	\$436	\$537	\$578	\$655	\$672
Subscriber + Children	\$450	\$534	\$575	\$654	\$755	\$796	\$873	\$890
Subscriber, Spouse, Child	\$435	\$487	\$569	\$727	\$929	\$1,011	\$1,165	\$1,199
Subscriber, Spouse, Children	\$595	\$705	\$787	\$945	\$1,147	\$1,229	\$1,383	\$1,417
KP 3500/35/NM - Form BWDEDS35000113								
Child/Subscriber Only	\$139	\$165	\$205	\$280	\$378	\$418	\$492	\$508
Subscriber + Spouse	\$278	\$330	\$410	\$560	\$756	\$836	\$984	\$1,016
Subscriber + Child	\$278	\$304	\$344	\$419	\$517	\$557	\$631	\$647
Subscriber + Children	\$431	\$513	\$553	\$628	\$726	\$766	\$840	\$856
Subscriber, Spouse, Child	\$417	\$469	\$549	\$699	\$895	\$975	\$1,123	\$1,155
Subscriber, Spouse, Children	\$570	\$678	\$758	\$908	\$1,104	\$1,184	\$1,332	\$1,364
KP 5000/35/NM - Form BWDEDS50000113								
Child/Subscriber Only	\$138	\$151	\$188	\$257	\$346	\$383	\$451	\$465
Subscriber + Spouse	\$256	\$302	\$376	\$514	\$692	\$766	\$902	\$930
Subscriber + Child	\$256	\$279	\$316	\$385	\$474	\$511	\$579	\$593
Subscriber + Children	\$397	\$471	\$508	\$577	\$666	\$703	\$771	\$785
Subscriber, Spouse, Child	\$384	\$430	\$504	\$642	\$820	\$894	\$1,030	\$1,058
Subscriber, Spouse, Children	\$525	\$622	\$696	\$834	\$1,012	\$1,086	\$1,222	\$1,250
KP 7500/35/NM - Form BWDEDS75000113								
Child/Subscriber Only	\$118	\$119	\$173	\$236	\$319	\$352	\$415	\$429
Subscriber + Spouse	\$236	\$278	\$346	\$472	\$638	\$704	\$830	\$858
Subscriber + Child	\$236	\$257	\$291	\$354	\$437	\$470	\$533	\$547
Subscriber + Children	\$366	\$434	\$468	\$531	\$614	\$647	\$710	\$724
Subscriber, Spouse, Child	\$354	\$396	\$464	\$590	\$756	\$822	\$948	\$976
Subscriber, Spouse, Children	\$484	\$573	\$641	\$767	\$933	\$999	\$1,125	\$1,153

Kaiser Foundation Health Plan of the Northwest
KP Individuals and Families Plans - Open Plans
New Plans Open to New Enrollees on or after January 1, 2011
Other than Clark County - Non-Smoker Rates
Effective January 1, 2013 Through December 31, 2013
Enrolled after 12/31/2010

Subscriber Tier	Subscriber Age									
	<25	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	
KP 1000/25/Rx - Form BWDEDS10000113, RWRXGU0113, RWYH0113										
Child/Subscriber Only	\$216	\$257	\$266	\$329	\$406	\$480	\$403	\$700	\$816	
Subscriber + Spouse	\$436	\$514	\$572	\$658	\$812	\$960	\$1,206	\$1,400	\$1,632	
Subscriber + Child	\$436	\$475	\$504	\$547	\$624	\$698	\$821	\$918	\$1,034	
Subscriber + Children	\$676	\$802	\$831	\$874	\$951	\$1,023	\$1,148	\$1,245	\$1,361	
Subscriber, Spouse, Child	\$654	\$732	\$790	\$876	\$1,030	\$1,178	\$1,424	\$1,618	\$1,850	
Subscriber, Spouse, Children	\$894	\$1,059	\$1,117	\$1,203	\$1,357	\$1,505	\$1,751	\$1,945	\$2,177	
KP 1500/30/Rx - Form BWDEDS15000113, RWRXGU0113										
Child/Subscriber Only	\$186	\$221	\$227	\$295	\$364	\$432	\$541	\$629	\$733	
Subscriber + Spouse	\$392	\$462	\$514	\$590	\$728	\$864	\$1,082	\$1,258	\$1,466	
Subscriber + Child	\$392	\$427	\$453	\$491	\$560	\$628	\$737	\$825	\$929	
Subscriber + Children	\$608	\$721	\$747	\$785	\$854	\$922	\$1,031	\$1,119	\$1,223	
Subscriber, Spouse, Child	\$588	\$658	\$710	\$786	\$924	\$1,060	\$1,278	\$1,454	\$1,662	
Subscriber, Spouse, Children	\$804	\$952	\$1,004	\$1,080	\$1,218	\$1,354	\$1,572	\$1,748	\$1,956	
KP 2500/30/Rx - Form BWDEDS25000113, RWRXGU0113										
Child/Subscriber Only	\$182	\$216	\$239	\$275	\$340	\$403	\$505	\$587	\$682	
Subscriber + Spouse	\$364	\$432	\$478	\$550	\$680	\$806	\$1,010	\$1,174	\$1,364	
Subscriber + Child	\$364	\$398	\$421	\$457	\$522	\$585	\$687	\$769	\$864	
Subscriber + Children	\$564	\$671	\$694	\$730	\$795	\$858	\$960	\$1,042	\$1,137	
Subscriber, Spouse, Child	\$546	\$614	\$660	\$732	\$862	\$988	\$1,192	\$1,356	\$1,546	
Subscriber, Spouse, Children	\$746	\$887	\$933	\$1,005	\$1,135	\$1,261	\$1,465	\$1,629	\$1,819	
KP 3500/30/Rx - Form BWDEDS35000113, RWRXGU0113										
Child/Subscriber Only	\$175	\$207	\$230	\$265	\$327	\$387	\$485	\$564	\$656	
Subscriber + Spouse	\$350	\$414	\$460	\$530	\$654	\$774	\$970	\$1,128	\$1,312	
Subscriber + Child	\$350	\$382	\$405	\$440	\$502	\$562	\$660	\$739	\$831	
Subscriber + Children	\$543	\$645	\$668	\$703	\$765	\$825	\$923	\$1,002	\$1,094	
Subscriber, Spouse, Child	\$525	\$589	\$635	\$705	\$829	\$949	\$1,145	\$1,303	\$1,487	
Subscriber, Spouse, Children	\$718	\$852	\$898	\$968	\$1,092	\$1,212	\$1,408	\$1,566	\$1,750	
KP 5000/30/Rx - Form BWDEDS50000113, RWRXGU0113										
Child/Subscriber Only	\$160	\$189	\$210	\$242	\$298	\$353	\$443	\$515	\$600	
Subscriber + Spouse	\$320	\$378	\$420	\$484	\$596	\$706	\$886	\$1,030	\$1,200	
Subscriber + Child	\$320	\$349	\$370	\$402	\$458	\$513	\$603	\$675	\$760	
Subscriber + Children	\$496	\$589	\$610	\$642	\$698	\$753	\$843	\$915	\$1,000	
Subscriber, Spouse, Child	\$480	\$538	\$580	\$644	\$756	\$866	\$1,046	\$1,190	\$1,360	
Subscriber, Spouse, Children	\$656	\$778	\$820	\$884	\$996	\$1,106	\$1,286	\$1,430	\$1,600	
KP 7500/30/Rx - Form BWDEDS75000113, RWRXGU0113										
Child/Subscriber Only	\$147	\$174	\$193	\$222	\$274	\$324	\$406	\$472	\$551	
Subscriber + Spouse	\$294	\$348	\$386	\$444	\$548	\$648	\$812	\$944	\$1,102	
Subscriber + Child	\$294	\$321	\$340	\$369	\$421	\$471	\$553	\$619	\$698	
Subscriber + Children	\$456	\$542	\$561	\$590	\$642	\$692	\$774	\$840	\$919	
Subscriber, Spouse, Child	\$441	\$495	\$533	\$591	\$695	\$795	\$959	\$1,091	\$1,249	
Subscriber, Spouse, Children	\$603	\$716	\$754	\$812	\$916	\$1,016	\$1,180	\$1,312	\$1,470	
KP 1500/35/NM - Form BWDEDS15000113										
Child/Subscriber Only	\$128	\$152	\$188	\$258	\$347	\$384	\$452	\$467	\$480	
Subscriber + Spouse	\$256	\$304	\$376	\$516	\$694	\$768	\$904	\$934	\$960	
Subscriber + Child	\$256	\$280	\$316	\$386	\$475	\$512	\$580	\$595	\$608	
Subscriber + Children	\$397	\$472	\$508	\$578	\$667	\$704	\$772	\$787	\$800	
Subscriber, Spouse, Child	\$384	\$432	\$504	\$644	\$822	\$896	\$1,032	\$1,062	\$1,088	
Subscriber, Spouse, Children	\$525	\$624	\$696	\$836	\$1,014	\$1,088	\$1,224	\$1,254	\$1,280	
KP 2500/35/NM - Form BWDEDS25000113										
Child/Subscriber Only	\$124	\$147	\$182	\$249	\$336	\$372	\$438	\$452	\$465	
Subscriber + Spouse	\$248	\$294	\$364	\$498	\$672	\$744	\$876	\$904	\$930	
Subscriber + Child	\$248	\$271	\$305	\$373	\$460	\$496	\$562	\$576	\$589	
Subscriber + Children	\$384	\$457	\$492	\$559	\$646	\$682	\$748	\$762	\$775	
Subscriber, Spouse, Child	\$372	\$418	\$488	\$622	\$796	\$868	\$1,000	\$1,028	\$1,054	
Subscriber, Spouse, Children	\$508	\$604	\$674	\$808	\$982	\$1,054	\$1,186	\$1,214	\$1,240	
KP 5000/35/NM - Form BWDEDS50000113										
Child/Subscriber Only	\$115	\$136	\$168	\$231	\$311	\$344	\$405	\$418	\$430	
Subscriber + Spouse	\$230	\$272	\$336	\$462	\$622	\$688	\$810	\$836	\$860	
Subscriber + Child	\$230	\$251	\$283	\$346	\$426	\$459	\$520	\$533	\$545	
Subscriber + Children	\$357	\$424	\$456	\$519	\$599	\$632	\$693	\$706	\$718	
Subscriber, Spouse, Child	\$345	\$387	\$451	\$577	\$737	\$803	\$925	\$951	\$975	
Subscriber, Spouse, Children	\$472	\$560	\$624	\$750	\$910	\$976	\$1,098	\$1,124	\$1,148	
KP 7500/35/NM - Form BWDEDS75000113										
Child/Subscriber Only	\$107	\$126	\$157	\$214	\$289	\$319	\$376	\$388	\$400	
Subscriber + Spouse	\$214	\$252	\$314	\$428	\$578	\$638	\$752	\$776	\$800	
Subscriber + Child	\$214	\$233	\$264	\$321	\$396	\$426	\$483	\$495	\$507	
Subscriber + Children	\$332	\$394	\$425	\$482	\$557	\$587	\$644	\$656	\$668	
Subscriber, Spouse, Child	\$321	\$359	\$421	\$535	\$685	\$743	\$859	\$883	\$907	
Subscriber, Spouse, Children	\$439	\$520	\$582	\$696	\$846	\$906	\$1,020	\$1,044	\$1,068	

Kaiser Foundation Health Plan of the Northwest
KP Individuals and Families Plans - Open Plans
New Plans Open to New Enrollees on or after January 1, 2011
Other than Clark County - Smoker Rates
Effective January 1, 2013 Through December 31, 2013
Enrolled after 12/31/2010

Subscriber Tier	Subscriber Age									
	<25	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	
KP 1080/25/Rs - Farm BWDEDS10000113, RWRXGUG113, RWWH010113										
Child/Subscriber Only	\$264	\$312	\$347	\$399	\$492	\$583	\$731	\$850	\$990	
Subscriber + Spouse	\$528	\$624	\$694	\$798	\$984	\$1,166	\$1,462	\$1,700	\$1,980	
Subscriber + Child	\$528	\$576	\$611	\$663	\$756	\$847	\$995	\$1,114	\$1,254	
Subscriber + Children	\$818	\$972	\$1,007	\$1,059	\$1,152	\$1,243	\$1,391	\$1,510	\$1,650	
Subscriber, Spouse, Child	\$792	\$888	\$958	\$1,062	\$1,248	\$1,470	\$1,726	\$1,964	\$2,244	
Subscriber, Spouse, Children	\$1,082	\$1,284	\$1,354	\$1,458	\$1,644	\$1,826	\$2,122	\$2,360	\$2,640	
KP 1500/30/Rs - Farm BWDEDS15000113, RWRXGUG113										
Child/Subscriber Only	\$237	\$280	\$310	\$357	\$441	\$522	\$655	\$761	\$887	
Subscriber + Spouse	\$474	\$560	\$620	\$714	\$882	\$1,044	\$1,310	\$1,522	\$1,774	
Subscriber + Child	\$474	\$517	\$547	\$594	\$678	\$759	\$892	\$998	\$1,124	
Subscriber + Children	\$735	\$873	\$903	\$950	\$1,034	\$1,115	\$1,248	\$1,354	\$1,480	
Subscriber, Spouse, Child	\$711	\$797	\$857	\$951	\$1,119	\$1,281	\$1,547	\$1,759	\$2,011	
Subscriber, Spouse, Children	\$972	\$1,153	\$1,213	\$1,307	\$1,475	\$1,637	\$1,903	\$2,115	\$2,367	
KP 2500/30/Rs - Farm BWDEDS25000113, RWRXGUG113										
Child/Subscriber Only	\$220	\$260	\$289	\$332	\$410	\$486	\$609	\$708	\$825	
Subscriber + Spouse	\$440	\$520	\$578	\$664	\$820	\$972	\$1,218	\$1,416	\$1,650	
Subscriber + Child	\$440	\$480	\$509	\$552	\$630	\$706	\$829	\$928	\$1,045	
Subscriber + Children	\$682	\$810	\$839	\$882	\$960	\$1,036	\$1,159	\$1,258	\$1,375	
Subscriber, Spouse, Child	\$660	\$740	\$798	\$884	\$1,040	\$1,192	\$1,438	\$1,636	\$1,870	
Subscriber, Spouse, Children	\$902	\$1,070	\$1,128	\$1,214	\$1,370	\$1,522	\$1,768	\$1,966	\$2,200	
KP 3500/30/Rs - Farm BWDEDS35000113, RWRXGUG113										
Child/Subscriber Only	\$211	\$250	\$277	\$319	\$394	\$466	\$585	\$679	\$791	
Subscriber + Spouse	\$422	\$500	\$554	\$638	\$788	\$932	\$1,170	\$1,358	\$1,582	
Subscriber + Child	\$422	\$461	\$488	\$530	\$605	\$677	\$796	\$880	\$1,002	
Subscriber + Children	\$654	\$778	\$805	\$847	\$922	\$994	\$1,113	\$1,207	\$1,319	
Subscriber, Spouse, Child	\$633	\$711	\$765	\$849	\$999	\$1,143	\$1,381	\$1,569	\$1,793	
Subscriber, Spouse, Children	\$865	\$1,028	\$1,082	\$1,166	\$1,316	\$1,460	\$1,698	\$1,886	\$2,110	
KP 4500/30/Rs - Farm BWDEDS45000113, RWRXGUG113										
Child/Subscriber Only	\$192	\$227	\$252	\$290	\$358	\$424	\$532	\$618	\$720	
Subscriber + Spouse	\$384	\$454	\$504	\$580	\$716	\$848	\$1,064	\$1,236	\$1,440	
Subscriber + Child	\$384	\$419	\$444	\$482	\$550	\$616	\$724	\$810	\$912	
Subscriber + Children	\$595	\$707	\$732	\$770	\$838	\$904	\$1,012	\$1,098	\$1,200	
Subscriber, Spouse, Child	\$576	\$646	\$696	\$772	\$908	\$1,040	\$1,256	\$1,428	\$1,632	
Subscriber, Spouse, Children	\$787	\$934	\$984	\$1,060	\$1,196	\$1,328	\$1,544	\$1,716	\$1,920	
KP 5500/30/Rs - Farm BWDEDS55000113, RWRXGUG113										
Child/Subscriber Only	\$176	\$208	\$231	\$265	\$327	\$388	\$486	\$565	\$659	
Subscriber + Spouse	\$352	\$416	\$462	\$530	\$654	\$776	\$972	\$1,130	\$1,318	
Subscriber + Child	\$352	\$384	\$407	\$441	\$503	\$564	\$662	\$741	\$835	
Subscriber + Children	\$546	\$648	\$671	\$705	\$767	\$828	\$926	\$1,005	\$1,099	
Subscriber, Spouse, Child	\$528	\$592	\$638	\$706	\$830	\$952	\$1,148	\$1,306	\$1,494	
Subscriber, Spouse, Children	\$722	\$856	\$902	\$970	\$1,094	\$1,216	\$1,412	\$1,570	\$1,758	
KP 6500/35/NM - Farm BWDEDS65000113										
Child/Subscriber Only	\$114	\$182	\$226	\$309	\$416	\$460	\$542	\$560	\$576	
Subscriber + Spouse	\$308	\$564	\$472	\$618	\$832	\$920	\$1,084	\$1,120	\$1,152	
Subscriber + Child	\$308	\$336	\$380	\$463	\$570	\$614	\$696	\$714	\$730	
Subscriber + Children	\$477	\$567	\$611	\$694	\$801	\$845	\$927	\$945	\$961	
Subscriber, Spouse, Child	\$462	\$518	\$606	\$722	\$860	\$1,074	\$1,238	\$1,274	\$1,306	
Subscriber, Spouse, Children	\$631	\$749	\$837	\$1,003	\$1,217	\$1,305	\$1,469	\$1,505	\$1,537	
KP 7500/35/NM - Farm BWDEDS75000113										
Child/Subscriber Only	\$148	\$176	\$218	\$298	\$402	\$445	\$524	\$541	\$555	
Subscriber + Spouse	\$296	\$352	\$436	\$596	\$804	\$890	\$1,048	\$1,082	\$1,110	
Subscriber + Child	\$296	\$324	\$366	\$446	\$550	\$593	\$672	\$689	\$703	
Subscriber + Children	\$459	\$546	\$588	\$668	\$772	\$815	\$894	\$911	\$925	
Subscriber, Spouse, Child	\$444	\$500	\$584	\$744	\$952	\$1,038	\$1,196	\$1,230	\$1,258	
Subscriber, Spouse, Children	\$607	\$722	\$806	\$966	\$1,174	\$1,260	\$1,418	\$1,452	\$1,480	
KP 8500/35/NM - Farm BWDEDS85000113										
Child/Subscriber Only	\$177	\$162	\$201	\$275	\$371	\$410	\$483	\$498	\$513	
Subscriber + Spouse	\$274	\$324	\$402	\$550	\$742	\$820	\$966	\$996	\$1,026	
Subscriber + Child	\$274	\$299	\$338	\$412	\$508	\$547	\$620	\$635	\$650	
Subscriber + Children	\$425	\$505	\$544	\$618	\$714	\$753	\$826	\$841	\$856	
Subscriber, Spouse, Child	\$411	\$461	\$539	\$687	\$879	\$957	\$1,103	\$1,123	\$1,163	
Subscriber, Spouse, Children	\$562	\$667	\$745	\$893	\$1,085	\$1,163	\$1,309	\$1,339	\$1,369	
KP 9500/35/NM - Farm BWDEDS95000113										
Child/Subscriber Only	\$127	\$150	\$186	\$255	\$343	\$379	\$447	\$461	\$475	
Subscriber + Spouse	\$254	\$300	\$372	\$510	\$686	\$758	\$894	\$922	\$950	
Subscriber + Child	\$254	\$277	\$313	\$382	\$470	\$506	\$574	\$588	\$602	
Subscriber + Children	\$394	\$468	\$504	\$573	\$661	\$697	\$765	\$779	\$793	
Subscriber, Spouse, Child	\$381	\$427	\$499	\$637	\$813	\$885	\$1,021	\$1,049	\$1,077	
Subscriber, Spouse, Children	\$521	\$618	\$690	\$828	\$1,004	\$1,076	\$1,212	\$1,240	\$1,268	

Lifewise Health Plan of Washington

2013 Monthly Rates for Individual Market Plans

Effective 1/1/2013

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Per Adult	Comprehensive Plan	
	WiseAdvantage (\$1,800 Ded)	
	Non-Smoker	Smoker
Age Band		
<25	\$273	\$319
25-29	\$310	\$359
30-34	\$357	\$414
35-39	\$427	\$497
40-44	\$501	\$586
45-49	\$629	\$728
50-54	\$771	\$897
55-59	\$897	\$1,040
60+	\$1,021	\$1,194
Per Child	\$230	

Per Adult	HSA Compatible Plans							
	WiseSavings 20 Plan (\$1,970 Ded) IND		WiseSavings 20 Plan (\$3,940 Ded) FAM		WiseSavings 20 Plan (\$3,000 Ded) IND		WiseSavings 20 Plan (\$6,000 Ded) FAM	
	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker
Age Band								
<25	\$194	\$225	\$143	\$168	\$154	\$182	\$121	\$139
25-29	\$219	\$255	\$161	\$189	\$175	\$204	\$133	\$154
30-34	\$254	\$293	\$188	\$217	\$204	\$239	\$154	\$181
35-39	\$301	\$353	\$223	\$261	\$246	\$282	\$183	\$217
40-44	\$356	\$417	\$263	\$307	\$291	\$336	\$218	\$256
45-49	\$447	\$516	\$330	\$381	\$361	\$420	\$275	\$316
50-54	\$546	\$636	\$405	\$470	\$441	\$513	\$336	\$393
55-59	\$636	\$739	\$470	\$546	\$517	\$597	\$393	\$456
60+	\$723	\$843	\$534	\$626	\$576	\$682	\$443	\$518
Per Child	N/A		\$122		N/A		\$100	

Lifewise Health Plan of Washington

2013 Monthly Rates for Individual Market Plans
Effective 1/1/2013
Page Two

Per Adult	Value Plan					
	WiseEssentials 6 (\$1,970 Ded)		WiseEssentials 6 (\$2,500 Ded)		WiseEssentials 6 (\$3,500 Ded)	
Age Band	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker
<25	\$160	\$188	\$139	\$164	\$124	\$149
25-29	\$183	\$211	\$158	\$183	\$143	\$166
30-34	\$210	\$244	\$181	\$209	\$164	\$191
35-39	\$250	\$293	\$218	\$254	\$196	\$229
40-44	\$294	\$345	\$255	\$298	\$230	\$270
45-49	\$369	\$427	\$320	\$372	\$291	\$336
50-54	\$452	\$527	\$393	\$458	\$355	\$414
55-59	\$527	\$611	\$458	\$529	\$414	\$479
60+	\$598	\$702	\$521	\$608	\$465	\$549
Per Child	\$135		\$116		\$106	

Per Adult	Value Plan					
	WiseEssentials Copay (\$5,000 Ded)		WiseEssentials Copay (\$7,500 Ded)		WiseSimplicity (\$10,000 Ded)	
Age Band	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker
<25	\$119	\$140	\$97	\$116	\$87	\$100
25-29	\$134	\$156	\$113	\$129	\$96	\$111
30-34	\$155	\$182	\$127	\$149	\$111	\$130
35-39	\$188	\$219	\$153	\$179	\$133	\$155
40-44	\$220	\$257	\$180	\$212	\$156	\$185
45-49	\$276	\$318	\$227	\$260	\$197	\$228
50-54	\$339	\$393	\$276	\$321	\$241	\$282
55-59	\$393	\$458	\$321	\$374	\$282	\$327
60+	\$446	\$522	\$363	\$428	\$319	\$372
Per Child	\$100		\$81		\$70	

ODS Health Plan, Inc.

Monthly Rates for Individual Market Plans
Effective 8/1/2012

Plan Name	Area	Tobacco/Non-Tobacco	Dep. Child	Age Band 0-24	Age Band 25-29	Age Band 30-34	Age Band 35-39	Age Band 40-44	Age Band 45-49	Age Band 50-54	Age Band 55-59	Age Band 60-64	Age Band 65+
ODS Premium \$1,500	Western	Tobacco	\$215	\$300	\$337	\$388	\$466	\$550	\$682	\$840	\$975	\$1,118	\$1,118
		Non-Tobacco	\$215	\$256	\$292	\$333	\$400	\$468	\$590	\$722	\$840	\$956	\$956
	Eastern	Tobacco	\$224	\$312	\$350	\$404	\$484	\$571	\$709	\$873	\$1,014	\$1,163	\$1,163
		Non-Tobacco	\$224	\$266	\$303	\$347	\$416	\$487	\$614	\$750	\$873	\$994	\$994
ODS Hybrid \$2,500	Western	Tobacco	\$109	\$153	\$172	\$196	\$238	\$280	\$347	\$429	\$497	\$569	\$569
		Non-Tobacco	\$109	\$131	\$148	\$170	\$204	\$239	\$301	\$369	\$429	\$489	\$489
	Eastern	Tobacco	\$114	\$159	\$179	\$204	\$247	\$291	\$361	\$446	\$517	\$592	\$592
		Non-Tobacco	\$114	\$136	\$153	\$177	\$212	\$248	\$312	\$383	\$446	\$508	\$508
ODS Hybrid \$3,500	Western	Tobacco	\$98	\$139	\$156	\$178	\$214	\$253	\$313	\$387	\$448	\$513	\$513
		Non-Tobacco	\$98	\$117	\$133	\$153	\$183	\$215	\$271	\$331	\$387	\$438	\$438
	Eastern	Tobacco	\$102	\$144	\$162	\$185	\$223	\$263	\$326	\$402	\$465	\$533	\$533
		Non-Tobacco	\$102	\$122	\$138	\$160	\$191	\$224	\$281	\$345	\$402	\$455	\$455
ODS Basic \$5,000	Western	Tobacco	\$75	\$106	\$119	\$138	\$166	\$195	\$242	\$299	\$347	\$397	\$397
		Non-Tobacco	\$75	\$91	\$103	\$118	\$143	\$167	\$210	\$256	\$299	\$340	\$340
	Eastern	Tobacco	\$78	\$111	\$124	\$143	\$172	\$203	\$251	\$311	\$361	\$413	\$413
		Non-Tobacco	\$78	\$95	\$107	\$123	\$148	\$173	\$218	\$266	\$311	\$353	\$353
ODS Basic \$7,500	Western	Tobacco	\$62	\$89	\$98	\$114	\$136	\$161	\$198	\$244	\$285	\$326	\$326
		Non-Tobacco	\$62	\$75	\$86	\$97	\$116	\$137	\$172	\$211	\$244	\$279	\$279
	Eastern	Tobacco	\$65	\$92	\$102	\$118	\$141	\$168	\$205	\$254	\$296	\$339	\$339
		Non-Tobacco	\$65	\$78	\$89	\$101	\$120	\$142	\$179	\$219	\$254	\$290	\$290
ODS HSA Individual \$2,500	Western	Tobacco	N/A	\$168	\$188	\$219	\$260	\$309	\$386	\$472	\$550	\$628	\$628
		Non-Tobacco	N/A	\$143	\$160	\$188	\$226	\$267	\$332	\$405	\$476	\$534	\$534
	Eastern	Tobacco	N/A	\$175	\$195	\$228	\$270	\$321	\$401	\$491	\$571	\$653	\$653
		Non-Tobacco	N/A	\$149	\$167	\$195	\$235	\$277	\$345	\$421	\$494	\$555	\$555
ODS HSA Family \$5,000	Western	Tobacco	\$91	\$128	\$143	\$167	\$199	\$236	\$292	\$361	\$419	\$477	\$477
		Non-Tobacco	\$91	\$111	\$123	\$143	\$169	\$200	\$252	\$309	\$361	\$407	\$407
	Eastern	Tobacco	\$94	\$133	\$148	\$174	\$207	\$245	\$304	\$375	\$436	\$495	\$495
		Non-Tobacco	\$94	\$115	\$128	\$148	\$176	\$208	\$262	\$321	\$375	\$423	\$423

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Premiera Blue Cross Individual Plans
Effective 1/1/2013

Per Adult	Preferred 35 Contract - 022360(01-2012)	
Age Band	Non-Smoker	Smoker
<25	\$325	\$377
25-29	\$384	\$448
30-34	\$403	\$464
35-39	\$448	\$521
40-44	\$592	\$689
45-49	\$689	\$799
50-54	\$789	\$920
55-59	\$958	\$1,113
60-64	\$1,118	\$1,299
65+	\$1,197	\$1,391
Per Child	\$246	

Regence BlueCross BlueShield of Oregon (Clark County)

Monthly Rates for Individual Plans

Rate Effective Date 12/1/2012

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Plan Name	Smoker/Non-Smoker	Child	Age Band 0-24	Age Band 25-29	Age Band 30-34	Age Band 35-39	Age Band 40-44	Age Band 45-49	Age Band 50-54	Age Band 55-59	Age Band 60+
Regence Evolve Core Plan, \$2,500 Deductible	Non-Smoker	\$139	\$139	\$159	\$185	\$218	\$257	\$311	\$370	\$434	\$509
	Smoker	\$139	\$160	\$183	\$213	\$251	\$296	\$358	\$426	\$499	\$585
Regence Evolve Core Plan, \$5,000 Deductible	Non-Smoker	\$115	\$115	\$132	\$154	\$181	\$213	\$258	\$307	\$361	\$423
	Smoker	\$115	\$133	\$152	\$177	\$209	\$245	\$297	\$353	\$415	\$486
Regence Evolve Core Plan, \$7,500 Deductible	Non-Smoker	\$104	\$104	\$120	\$139	\$164	\$193	\$234	\$279	\$327	\$383
	Smoker	\$104	\$120	\$138	\$160	\$189	\$223	\$269	\$320	\$376	\$441
Regence Evolve Core Plan, \$10,000 Deductible	Non-Smoker	\$96	\$96	\$111	\$128	\$152	\$178	\$216	\$257	\$301	\$353
	Smoker	\$96	\$111	\$127	\$148	\$174	\$205	\$248	\$295	\$347	\$406

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Regence BlueCross BlueShield of Oregon (Clark County)

Monthly Rates for Individual Plans

Rate Effective Date 12/1/2012

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Plan Name	Smoker/Non-Smoker	Child	Age Band 0-24	Age Band 25-29	Age Band 30-34	Age Band 35-39	Age Band 40-44	Age Band 45-49	Age Band 50-54	Age Band 55-59	Age Band 60+
Regence Evolve Plus Plan, \$1,000 Deductible	Non-Smoker	\$299	\$299	\$343	\$399	\$471	\$554	\$670	\$797	\$935	\$1,096
	Smoker	\$299	\$344	\$395	\$458	\$541	\$637	\$770	\$917	\$1,076	\$1,260
Regence Evolve Plus Plan, \$5,000 Deductible	Non-Smoker	\$194	\$194	\$223	\$259	\$306	\$360	\$436	\$519	\$609	\$713
	Smoker	\$194	\$224	\$257	\$298	\$352	\$414	\$501	\$596	\$700	\$820
Regence Evolve Plus Plan, \$7,500 Deductible	Non-Smoker	\$176	\$176	\$202	\$235	\$277	\$326	\$394	\$469	\$551	\$645
	Smoker	\$176	\$202	\$232	\$270	\$319	\$375	\$453	\$540	\$633	\$742

Regence BlueCross BlueShield of Oregon (Clark County)

Monthly Rates for Individual Plans

Rate Effective Date 12/1/2012

Page Three

Plan Name	Smoker/Non-Smoker	Child	Age Band 0-24	Age Band 25-29	Age Band 30-34	Age Band 35-39	Age Band 40-44	Age Band 45-49	Age Band 50-54	Age Band 55-59	Age Band 60+
Regence Evolve HSA 80 Plan, \$2,000/\$4,000 Deductible	Non-Smoker	\$183	\$183	\$210	\$244	\$289	\$339	\$411	\$489	\$574	\$672
	Smoker	\$183	\$211	\$242	\$281	\$332	\$390	\$472	\$562	\$660	\$773
Regence Evolve HSA 80 Plan, \$3,500/\$7,000 Deductible	Non-Smoker	\$147	\$147	\$169	\$196	\$231	\$272	\$329	\$392	\$460	\$539
	Smoker	\$147	\$169	\$194	\$225	\$266	\$313	\$378	\$450	\$529	\$619

Regence BlueShield**Monthly Rates for Individual Plans**

Rate Effective Date 10/1/2012

Page One

Plan Name	Smoker/Non-Smoker	Child	Age Band 0-24	Age Band 25-29	Age Band 30-34	Age Band 35-39	Age Band 40-44	Age Band 45-49	Age Band 50-54	Age Band 55-59	Age Band 60+
Regence Evolve Core Plan, \$2,500 Deductible	Non-Smoker	\$125	\$125	\$143	\$166	\$196	\$231	\$279	\$333	\$390	\$457
	Smoker	\$125	\$143	\$165	\$191	\$226	\$266	\$321	\$382	\$449	\$526
Regence Evolve Core Plan, \$5,000 Deductible	Non-Smoker	\$103	\$103	\$118	\$137	\$161	\$190	\$230	\$274	\$321	\$376
	Smoker	\$103	\$118	\$135	\$157	\$186	\$218	\$264	\$315	\$369	\$433
Regence Evolve Core Plan, \$7,500 Deductible	Non-Smoker	\$89	\$89	\$102	\$119	\$140	\$165	\$200	\$238	\$279	\$327
	Smoker	\$89	\$102	\$118	\$137	\$161	\$190	\$230	\$273	\$321	\$376
Regence Evolve Core Plan, \$10,000 Deductible	Non-Smoker	\$80	\$80	\$92	\$107	\$126	\$148	\$180	\$214	\$251	\$294
	Smoker	\$80	\$92	\$106	\$123	\$145	\$171	\$206	\$246	\$288	\$338

Regence BlueShield

Monthly Rates for Individual Plans

Rate Effective Date 10/1/2012

Page Two

Plan Name	Smoker/Non-Smoker	Child	Age Band 0-24	Age Band 25-29	Age Band 30-34	Age Band 35-39	Age Band 40-44	Age Band 45-49	Age Band 50-54	Age Band 55-59	Age Band 60+
Regence Evolve Plus Plan, \$1,000 Deductible	Non-Smoker	\$271	\$271	\$311	\$361	\$427	\$502	\$607	\$723	\$848	\$994
	Smoker	\$271	\$312	\$358	\$416	\$491	\$577	\$698	\$831	\$976	\$1,143
Regence Evolve Plus Plan, \$5,000 Deductible	Non-Smoker	\$170	\$170	\$196	\$227	\$268	\$315	\$382	\$454	\$533	\$625
	Smoker	\$170	\$196	\$225	\$261	\$308	\$363	\$439	\$522	\$613	\$718
Regence Evolve Plus Plan, \$7,500 Deductible	Non-Smoker	\$154	\$154	\$177	\$206	\$243	\$286	\$346	\$411	\$483	\$566
	Smoker	\$154	\$177	\$204	\$237	\$279	\$329	\$397	\$473	\$555	\$650

Regence BlueShield**Monthly Rates for Individual Plans**

Rate Effective Date 10/1/2012

Page Three

Plan Name	Smoker/Non-Smoker	Child	Age Band 0-24	Age Band 25-29	Age Band 30-34	Age Band 35-39	Age Band 40-44	Age Band 45-49	Age Band 50-54	Age Band 55-59	Age Band 60+
Regence Evolve HSA 80 Plan, \$2,000/\$4,000 Deductible	Non-Smoker	\$162	\$162	\$186	\$216	\$255	\$300	\$363	\$432	\$508	\$595
	Smoker	\$162	\$186	\$214	\$249	\$294	\$345	\$418	\$497	\$584	\$684
Regence Evolve HSA 80 Plan, \$3,500/\$7,000 Deductible	Non-Smoker	\$130	\$130	\$149	\$173	\$204	\$240	\$291	\$346	\$406	\$476
	Smoker	\$130	\$149	\$171	\$199	\$235	\$276	\$334	\$398	\$467	\$547

TIME INSURANCE COMPANY
CATASTROPHIC PLAN
NON-GRANDFATHERED PLANS
NON-TOBACCO RATES
EFFECTIVE JANUARY 2013

Deductible	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$3,000	\$3,000	\$3,000	\$3,000	\$5,000	\$5,000	\$5,000	\$5,000	\$10,000	\$10,000	\$10,000	\$10,000	
Coin	25%	25%	50%	50%	50%	25%	25%	50%	50%	25%	25%	50%	50%	25%	25%	50%	50%	
Out of Pocket w/Ded	\$4,500	\$7,000	\$7,000	\$12,000	\$22,000	\$5,500	\$8,000	\$8,000	\$13,000	\$7,500	\$10,000	\$10,000	\$15,000	\$12,500	\$15,000	\$15,000	\$20,000	
Area	Age																	
Rural	Under 25	\$188.66	\$170.87	\$151.06	\$132.59	\$121.18	\$155.99	\$141.32	\$125.00	\$109.79	\$132.78	\$120.34	\$106.49	\$93.59	\$102.14	\$92.64	\$82.06	\$72.20
	25-29	211.87	191.85	169.57	148.79	135.95	175.11	158.62	140.25	123.14	149.00	135.00	119.43	104.91	114.54	103.85	91.95	80.85
	30-34	244.36	221.23	195.48	171.47	156.63	201.88	182.82	161.60	141.82	171.71	155.54	137.54	120.76	131.89	119.53	105.78	92.96
	35-39	290.78	263.20	232.49	203.87	186.18	240.13	217.40	192.10	168.52	204.15	184.88	163.41	143.41	156.68	141.95	125.55	110.27
	40-44	346.48	313.56	276.91	242.75	221.63	286.03	258.90	228.70	200.56	243.08	220.07	194.46	170.58	186.41	168.83	149.26	131.02
	45-49	430.02	389.10	343.54	301.07	274.81	354.87	321.15	283.60	248.61	301.49	272.88	241.03	211.35	231.03	209.17	184.84	162.17
	50-54	524.85	475.03	419.57	367.86	335.90	433.36	392.30	346.60	304.00	368.37	333.54	294.78	258.64	282.60	255.99	226.38	198.77
	55-59	617.68	558.96	493.59	432.66	394.99	509.84	461.46	407.60	357.39	433.27	392.22	346.53	303.93	332.17	300.81	265.91	233.37
	60-64	701.23	634.50	560.22	490.97	448.17	578.69	523.70	462.50	405.44	491.66	445.02	393.09	344.69	376.78	341.15	301.49	264.51
	Child	132.96	120.50	106.64	93.71	85.72	110.09	99.83	88.40	77.75	93.84	85.13	75.44	66.41	72.40	65.75	58.34	51.44
Urban	Under 25	\$197.68	\$179.02	\$158.25	\$138.89	\$126.92	\$163.42	\$148.04	\$130.93	\$114.97	\$139.08	\$126.04	\$111.52	\$97.99	\$106.96	\$96.99	\$85.90	\$75.56
	25-29	222.02	201.02	177.66	155.88	142.41	183.47	166.18	146.92	128.97	156.09	141.42	125.08	109.86	119.96	108.75	96.27	84.64
	30-34	256.09	231.83	204.83	179.66	164.10	211.54	191.56	169.31	148.57	179.90	162.95	144.08	126.48	138.15	125.19	110.78	97.33
	35-39	304.76	275.84	243.64	213.63	195.08	251.65	227.82	201.29	176.56	213.93	193.71	171.21	150.23	164.14	148.70	131.51	115.48
	40-44	363.16	328.65	290.22	254.40	232.25	299.78	271.33	239.67	210.15	254.75	230.62	203.76	178.72	195.32	176.89	156.37	137.24
	45-49	450.77	407.85	360.08	315.55	288.02	371.96	336.60	297.24	260.54	315.99	285.99	252.60	221.47	242.11	219.19	193.68	169.90
	50-54	590.11	497.86	439.71	385.49	351.98	454.17	411.12	363.20	318.52	386.02	349.51	308.85	270.96	296.08	268.19	237.13	208.18
	55-59	647.45	585.88	517.33	453.44	413.94	534.37	483.64	427.16	374.51	454.07	411.03	363.12	318.46	348.06	315.18	278.58	244.46
	60-64	735.05	665.08	587.19	514.58	469.70	606.56	548.90	484.72	424.89	515.30	466.39	411.95	361.20	394.85	357.48	315.89	277.12
	Child	139.27	126.21	111.67	98.12	89.74	115.29	104.53	92.55	81.38	98.25	89.12	78.96	69.49	75.77	68.79	61.03	53.79

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Rural Zip Codes: 986, 988-994 Urban Zip Codes: 980-985

TIME INSURANCE COMPANY
CATASTROPHIC PLAN
NON-GRANDFATHERED PLANS
TOBACCO RATES
EFFECTIVE JANUARY 2013

Deductible	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$3,000	\$3,000	\$3,000	\$3,000	\$5,000	\$5,000	\$5,000	\$5,000	\$10,000	\$10,000	\$10,000	\$10,000	
Coin	25%	25%	50%	50%	50%	25%	25%	50%	50%	25%	25%	50%	50%	25%	25%	50%	50%	
Out of Pocket w/Ded	\$4,500	\$7,000	\$7,000	\$12,000	\$22,000	\$5,500	\$8,000	\$8,000	\$13,000	\$7,500	\$10,000	\$10,000	\$15,000	\$12,500	\$15,000	\$15,000	\$20,000	
Area	Age																	
Rural	Under 25	\$225.79	\$204.44	\$180.67	\$158.51	\$144.81	\$186.58	\$168.99	\$149.40	\$131.14	\$158.74	\$143.81	\$127.19	\$111.70	\$121.97	\$110.57	\$97.87	\$86.04
	25-29	253.64	229.62	202.88	177.95	162.54	209.53	189.74	167.70	147.16	178.20	161.41	142.71	125.29	136.84	124.02	109.74	96.42
	30-34	292.63	264.87	233.97	205.17	187.36	241.66	218.78	193.32	169.59	205.45	186.05	164.45	144.31	157.66	142.84	126.34	110.96
	35-39	348.33	315.23	278.39	244.05	222.81	287.56	260.29	229.93	201.62	244.39	221.25	195.50	171.49	187.41	169.74	150.06	131.72
	40-44	415.17	375.67	331.69	290.70	265.36	342.63	310.08	273.85	240.07	291.10	263.49	232.75	204.10	223.09	202.00	178.52	156.63
	45-49	515.43	466.31	411.64	360.68	329.17	425.24	384.77	339.72	297.73	361.18	326.86	288.64	253.02	276.63	250.41	221.21	194.00
	50-54	628.82	569.03	502.48	440.43	402.08	519.03	469.76	414.92	363.80	441.04	399.25	352.73	309.36	338.12	306.19	270.65	237.52
	55-59	740.22	669.75	591.31	518.19	472.99	610.81	552.75	488.12	427.86	518.92	469.66	414.83	363.72	397.60	359.97	318.09	279.04
	60-64	840.47	760.40	671.26	588.17	536.80	693.42	627.44	554.00	485.53	588.99	533.02	470.71	412.63	451.14	408.38	360.78	316.41
	Child	132.96	120.50	106.64	93.71	85.72	110.09	99.83	88.40	77.75	93.84	85.13	75.44	66.41	72.40	65.75	58.34	51.44
	Urban	Under 25	\$236.62	\$214.23	\$189.30	\$166.07	\$151.70	\$195.50	\$177.05	\$156.52	\$137.37	\$166.30	\$150.65	\$133.23	\$116.99	\$127.75	\$115.79	\$102.48
25-29		265.82	240.63	212.59	186.45	170.29	219.57	198.81	175.71	154.17	186.71	169.10	149.50	131.23	143.35	129.90	114.92	100.96
30-34		306.70	277.60	245.19	214.99	196.32	253.25	229.27	202.57	177.68	215.28	194.94	172.29	151.18	165.18	149.63	132.33	116.20
35-39		365.11	330.40	291.77	255.76	233.49	301.38	272.78	240.95	211.27	256.11	231.85	204.85	179.68	196.37	177.84	157.21	137.98
40-44		435.20	393.77	347.66	304.68	278.11	359.13	325.00	287.00	251.58	305.10	276.14	243.91	213.87	233.78	211.67	187.04	164.09
45-49		540.32	488.82	431.50	378.06	345.02	445.76	403.32	356.08	312.05	378.59	342.59	302.52	265.16	289.93	262.43	231.81	203.28
50-54		659.13	596.44	526.65	461.59	421.37	544.00	492.34	434.84	381.23	462.23	418.41	369.63	324.15	354.30	320.82	283.56	248.82
55-59		775.94	702.05	619.80	543.12	495.72	640.24	579.36	511.59	448.41	543.89	492.24	434.75	381.15	416.68	377.22	333.30	292.35
60-64		881.06	797.10	703.63	616.50	562.64	726.87	657.68	580.67	508.87	617.36	558.67	493.34	432.43	472.82	427.98	378.07	331.54
Child		139.27	126.21	111.67	98.12	89.74	115.29	104.53	92.55	81.38	98.25	89.12	78.96	69.49	75.77	68.79	61.03	53.79

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Rural Zip Codes: 986, 988-994 Urban Zip Codes: 980-985

TIME INSURANCE COMPANY
HSA PLAN
NON-GRANDFATHERED PLANS
EFFECTIVE JANUARY 2013

INDIVIDUAL				FAMILY	
Deductible	\$2,700	\$2,700		\$5,400	\$5,400
Coin	20%	20%		20%	20%
Out of Pocket w/Ded	\$4,700	\$4,700		\$9,400	\$9,400
Type:	NON-TOBACCO	TOBACCO		NON-TOBACCO	TOBACCO
Area	Age				
Rural	Under 25	\$174.44	\$208.73	\$153.93	\$184.11
	25-29	\$195.86	\$234.44	\$172.79	\$206.75
	30-34	\$225.87	\$270.44	\$199.21	\$238.45
	35-39	\$268.73	\$321.87	\$236.94	\$283.73
	40-44	\$320.17	\$383.60	\$282.21	\$338.05
	45-49	\$397.31	\$476.17	\$350.13	\$419.56
	50-54	\$485.03	\$581.03	\$427.59	\$512.11
	55-59	\$570.75	\$683.90	\$503.06	\$602.67
	60-64	\$647.90	\$776.48	\$570.97	\$684.16
	Child	\$123.01	\$123.01	\$108.64	\$108.64
Urban	Under 25	\$182.77	\$218.72	\$161.26	\$192.91
	25-29	\$205.23	\$245.68	\$181.04	\$216.65
	30-34	\$236.70	\$283.43	\$208.74	\$249.89
	35-39	\$281.64	\$337.37	\$248.31	\$297.37
	40-44	\$335.58	\$402.09	\$295.78	\$354.33
	45-49	\$416.47	\$499.16	\$367.00	\$439.80
	50-54	\$508.35	\$609.02	\$448.12	\$536.75
	55-59	\$598.23	\$716.88	\$527.26	\$631.71
	60-64	\$679.14	\$813.96	\$598.47	\$717.16
	Child	\$128.84	\$128.84	\$113.78	\$113.78

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Rural Zip Codes: 986, 988-994 Urban Zip Codes: 980-985

TIME INSURANCE COMPANY
COMPREHENSIVE PLAN
NON-GRANDFATHERED PLANS
EFFECTIVE JANUARY 2013

Deductible	\$1,500	\$1,500			
Coin	25%	25%			
Out of Pocket w/Ded	\$9,000	\$9,000			
Type:	NON-TOBACCO	TOBACCO			
Area	Age				
Rural	Under 25	\$306.75	\$368.10		
	25-29	\$345.09	\$414.11		
	30-34	\$398.77	\$478.53		
	35-39	\$475.46	\$570.55		
	40-44	\$567.48	\$680.98		
	45-49	\$705.52	\$846.63		
	50-54	\$858.90	\$1,030.68		
	55-59	\$1,012.27	\$1,214.72		
	60-64	\$1,150.30	\$1,380.36		
	Child	\$214.72	\$214.72		
Urban	Under 25	\$321.65	\$385.98		
	25-29	\$361.86	\$434.23		
	30-34	\$418.15	\$501.78		
	35-39	\$498.55	\$598.27		
	40-44	\$595.05	\$714.06		
	45-49	\$739.80	\$887.76		
	50-54	\$900.62	\$1,080.75		
	55-59	\$1,061.45	\$1,273.74		
	60-64	\$1,206.19	\$1,447.43		
	Child	\$225.16	\$225.16		

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Or visit us at www.insurance.wa.gov

Our professional consumer advocates provide assistance, enforce insurance law, and can investigate complaints against insurance companies and agents on your behalf.

We also offer individual counseling and group education on health care issues in your community. Our highly trained Statewide Health Insurance Benefits Advisors (SHIBA) volunteers can help you understand your rights and options regarding health care coverage, prescription drugs, government programs, long-term care options and more.



Post-Hearing Questions for the Record
Submitted to Hon. Mike Kreidler
From Senator Claire McCaskill

“The State of Health Insurance Markets”

September 15, 2016

In your testimony, you concluded that every state should be required to expand Medicaid and claim that it is the reason so many of the uninsured were able to get insurance on the exchanges. Please describe how you have seen the Medicaid expansion care for those in the “Medicaid gap”.

Washington state initially projected it would reach 262,000 newly-eligible adults through Medicaid expansion. Instead, close to 600,000 adults gained coverage through Washington’s Apple Health. This is the most significant factor behind drop in the uninsured.

Washington state does not have a Medicaid gap – our Medicaid expansion covers people up to the Qualified Health Plan (QHP) eligibility (138 percent FPL). Also, 70 percent of QHP enrollees qualify for premium tax credits and 70,000 have qualified for cost-sharing reductions. (*Report: Health Coverage Enrollment Report – March 2016*)

Our state is serving the Medicaid population and the lowest income QHP population well by coordinating and working together across systems. Our Medicaid director is a member of the state exchange and the both organizations work together to ensure that the “no wrong door” approach is working for people in the state of Washington. This coordination is evident by the low amount of fall-off and churn between the two types of coverage. (*Report: Churn Between WA Apple Health and QHPs - Jan. 2016*)

Prescription drug pricing is mentioned in all 4 testimonies. We’ve seen that when the price of pharmaceuticals goes up, the cost is often times directly passed to the consumer. In your experience with the Washington health exchanges, how has prescription drug pricing affected consumers especially those looking to purchase a plan on the exchanges?

We know that the majority of consumers enrolled through our exchange are taking advantage of premium tax credits to afford their coverage and that many enroll in silver-level plans to make coverage even more affordable.

However, it is true that higher income consumers, those with incomes above 250 percent of the federal poverty level are struggling to pay for care. Reports show that some of the hardest hit consumers are those that have chronic conditions for which expensive and routine prescription drugs are the only way to treat their conditions.

Our state legislature acknowledged the difficulty that all consumers with chronic disease, regardless of income, have with affording costly prescription drugs and established the Patient Out-of-Pocket Costs Taskforce to examine the issue. (*Senate Bill 6569*.)

The taskforce will report back to the legislature in December of this year, providing more details about how the state might address the issue of rising prescription drug costs.

**Post-Hearing Questions for the Record
Submitted to the Honorable Mike Kreidler
From Senator Jon Tester**

**Homeland Security and Governmental Affairs Hearing: "The State of Health Insurance Markets"
September 15, 2016**

- 1. Would the risk corridor program have better worked to stabilize insurance markets if Congress had not prohibited funding for it?**

Yes. If properly funded, the risk corridor program would have worked as it was intended and helped to stabilize the costs of health care for consumers now facing higher premiums. It also would have helped to bolster the health insurance market – particularly those insurers new to the individual markets.

- 2. Besides the changes that came from health care reform, what factors do you see contributing to the growth of health care costs, and what actions do you recommend to address these issues?**

The biggest impact on our health insurance rates this year was the growing cost of prescription drugs. As I said in my testimony, Congress must take action to curtail the rising costs of prescription drugs if they wish to address the growing costs of health insurance for consumers.

- 3. What steps do you recommend be taken to encourage more healthy people to invest in insurance coverage, or otherwise improve the risk pool in individual markets?**

I believe that one of the strongest incentives to encourage people to get covered is the tax penalty they have to pay for not getting covered. However, I do believe that the amount of the penalty is too low to truly encourage people to buy a health plan. Today, even with the penalty rising to \$700 for an individual, many people who do not believe they need health insurance, may see \$700 as a reasonable amount to pay versus paying monthly premiums for a year. Given this fact, I would encourage congress to increase the penalty amount to an amount that makes the trade-off less attractive.